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## CLINICAL LECTURE.

### CHRONIC HYDROCEPHALUS.— PRIMARY DENTITION.<sup>1</sup>

BY LOUIS STARR, M. D.,

CLINICAL PROFESSOR OF DISEASES OF CHILDREN IN THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA; VISITING PHYSICIAN TO THE CHILDREN'S HOSPITAL, PHILADELPHIA, ETC.

*Gentlemen:* I wish to ask your attention to-day to the condition known by the laity as "water on the brain," or scientifically speaking, hydrocephalus. A division into acute and chronic hydrocephalus is often made, but the term "acute hydrocephalus" is a bad one, for it merely indicates one result of a very distinct disease, namely, tubercular meningitis. We may put it to one side therefore, and devote our attention to chronic hydrocephalus.

<sup>1</sup>Delivered at the University Hospital.

Chronic hydrocephalus is a condition in which there is an accumulation of fluid, either in the ventricles of the brain or in the subarachnoid space; hence the division into internal and external hydrocephalus. The accumulative fluid is alkaline in reaction and is similar to the normal cerebro-spinal liquid, but has a higher specific gravity and contains a trace of albumin with sodium chloride and urea.

In addition to the divisions based upon the position of the accumulation of liquid, it is customary to divide chronic hydrocephalus into two varieties, viz., the congenital and the acquired.

Congenital hydrocephalus begins while the fetus is in utero, it is the form most commonly met with, and the accumulation of liquid is almost uniformly in the ventricles, or "internal." The quantity of liquid collected varies from a few ounces to several pounds. The causes of this form of disease are obscure, though there is probably always some precedent inflammation of the lining

membrane of the ventricles. Why this should occur is uncertain, but we usually get a history of intemperance, syphilis, rickets or some marked nervous disease, as epilepsy, in one or other parent. It is said also that hydrocephalus is very apt to occur in the children of men who have worked in lead and suffered from lead-poisoning. The cause, too, of congenital hydrocephalus is not a temporary one, for it is very common to find several successive children, born of the same mother, affected by the disease.

The first effects of the accumulation of liquid in the ventricles is exerted upon the brain tissues, the brain substance is thin and the convolutions become flattened. Next the bones of the skull feel the internal pressure and the head becomes distended. The frontal bone is pushed forward; the roofs of the orbit are depressed so as to flatten the sockets of the eyeballs, and the occipital bone and the squamous portions of the temporal bones are forced outwards almost horizontally. By the distending process all the sutures are widened, and the enlarged bulging fontanelles communicate by the sagittal suture. The shape of the head is almost always globular. Ossification of the cranial bones is delayed and small islets of bones (Wormian bones) form in the membranous interspaces. From this brief description of the morbid anatomy you can readily see that you must look to the head for the main symptoms of the disease. The head is large and globular, sometimes so heavy that it anchors the child to the bed, the veins of the scalp are dilated and prominently visible, the skin of the cranium seems to be thin and stretched, the hair is sparse and the fontanelles and sutures bulging and distinctly fluctuating on palpation. In contrast with the enlarged head we have a small pale face, presenting a peculiar expression of the eyes, the eyebrows are elevated, probably on account of the stretching of the skin of the scalp, the eyeballs project slightly, the axis of vision has a downward direction and the upper lid is retracted so as to expose the sclerotic above the iris, while the lower lid covers too much of the eye. Generally the frame is wanting in development, and the thin emaciated body presents a marked contrast to the enlarged head. The skin is pale and may be over-sensitive, although anaesthesia is the usual condition, while the muscles are flabby, and there is a marked deficiency in the subcutaneous fat. Of other symptoms I will mention

blindness from atrophy of the optic nerve; nystagmus, deafness, impaired intellect, unsteady gait in moderate cases, and absolute inability to walk in serious ones. Among the more marked nervous symptoms are laryngismus stridulus, general convulsions, muscular twitchings, spastic contractions of the limb, and temporary paralysis. Beyond spasmodic breathing the respiration is unaffected and the pulse with the exception of being weak and frequent shows no especial alteration. There is often excessive hunger and sometimes vomiting; the bowels are usually confined though the habitual sluggishness may be interrupted by occasional attacks of diarrhoea.

Of course the gravity of the symptoms varies with the size of the head, *i. e.*, the amount of liquid accumulation; on one hand, patients are seen who, with a moderately large head, present few symptoms, while, on the other hand, one sees cases of immense enlargement of the cranium where the child is unable to move without assistance, has no intellection, and leads almost a vegetable existence, simply eating, breathing, and sleeping. The case that I show you affords a good illustration of what I have said.

The patient, a girl six months old, is the second child, the first having been still-born. The father and mother are both healthy and one maternal uncle died of epilepsy. The mother states that the child was well formed at birth, and the enlargement of the head was not observed until the fourth month. About this time she began to have convulsions, having on some days as many as six; there was also frequent muscular twitching, spastic contraction of the right arm and leg, and, at times, temporary paralysis of these limbs. The child has shown some disturbance of gastric digestion and occasional attacks of diarrhoea. In this clinical history I would call attention to the statement that the child was born well formed. You will get this history in almost every case of congenital hydrocephalus, for although the disease begins while the child is in utero, the characteristic symptom—enlargement of the head—is rarely noticed until about the sixth month of life. As you see the case to-day you will notice that the child's head is decidedly enlarged and globular in shape and has a tendency to fall to either the one or other side, the skin of the cranium is thin and stretched looking, the hair is sparse and the veins on either side of

the head are quite prominent. On palpation the fontanelles are found to be large and bulging, and the sutures, especially the sagittal, widely open. The eyebrows and upper eyelids are somewhat elevated but on account of the moderate degree of enlargement the eyes do not show the characteristic features already mentioned.

You will observe the face is small in comparison to the size of the head, you see also from the pallor of the skin and from the small size of the trunk and limbs that the general nutrition is decidedly impaired. The tongue is somewhat coated, the appetite is poor, and the bowels confined. The two lower incisor teeth are about to be cut. This is an important factor in the diagnosis, as you will see later. Since the administration of bromide, which was begun a week ago, there have been no more convulsions, though a tendency to contraction and twitching of the muscles continues, and there is some hyperæsthesia of the surface.

In this case you see that many of the characteristic symptoms of the disease in question are illustrated. In regard to the diagnosis one point must be borne in mind, namely, that every enlarged head is not hydrocephalus. In rickets the head is often enlarged and the anterior fontanelle long in closing. The shape of the head, however, is square, the increase in size is never nearly so great as in hydrocephalus, dentition is markedly delayed, and we find other evidences of rachitic change in various bones of the skeleton. It must be remembered, however, that rickets and hydrocephalus often exist together. In syphilis, too, the head may be enlarged from thickening of the cranial bones, especially the frontal. Here again the enlargement is less extensive, and unmistakable evidences of the constitutional taint can usually be found upon the skin and mucous membrane.

The prognosis of congenital hydrocephalus is unfavorable, the majority of the patients die before the end of the second year, though in some cases the disease is arrested and individuals have been known to reach adult life and even old age. In these cases the head remains large and unsightly, and the intelligence is more or less blunted. Convulsions, twitching, contraction of the head and other signs of cerebral irritation are unfavorable symptoms. So again are continued wasting and looseness of the bowels. As there is almost uniformly impairment of nutrition, the occurrence of

any inter-current disease is apt to prove fatal.

Acquired hydrocephalus is a rare condition and usually occurs before the end of the third year. It is induced by any cause which interferes with the cerebral circulation, such as tumors pressing upon the veins of Galen or straight sinuses, impeding the escape of blood from the ventricles. Enlarged glands pressing upon the veins of the neck may produce the same result. It may also be a consequence of anemia, rickets, and other acute and chronic exhausting diseases which are attended by impoverishment of the blood. Again it may be one element of general dropsy due to disease of the heart or kidneys.

The fluid in acquired hydrocephalus is usually in the ventricles, or internal; it may, however, be found upon the surface of the brain and is then usually a consequence of meningeal hemorrhage.

The symptoms are very similar to those that occur in the congenital form, provided the effusion occurs before ossification of the skull is completed; if, on the other hand, it takes place after the fontanelles and sutures are closed the symptoms are obscure, for there is no distention of the cranium. The child usually becomes dull and heavy, there is headache, vertigo, and often a difficulty in supporting the head, so that the patient lies about and dreads movement. Walking is cautious and tottering, muscular twitching or convulsions come on, the pupils become sluggish and dilated, and the pulse becomes slow. Then there is stupor deepening into coma, and finally death.

The treatment of hydrocephalus is most unsatisfactory. One should endeavor to keep the child's digestion in good condition and to maintain the general nutrition by means of good food and tonics; of the latter the emulsion of cod liver oil with the lacto-phosphate of lime is probably the best. Good results have been claimed from a long-continued course of bichloride of mercury in minute doses, but I have had no experience with this method of treatment. Locally it is well to anoint the scalp with mercurial ointment, using oleate of mercury (50 per cent.) or compound iodine ointment. In applying these, the delicate condition of the skin must be borne in mind, and everything done to preserve the scalp intact by scrupulous cleanliness and occasional interruptions in the inunctions. Two plans of treatment have been suggested



neither of which have been very satisfactory in their results. The one consists in strapping the head, and the other in tapping the ventricles. In the first of these we must avoid making too much pressure. The hair should be shaved and the skin bathed with alcohol and water before each new application of the strap. Strips of ordinary rubber adhesive plaster one-half inch wide should be carried around the head from one occipital region to the corresponding temporal region, covering the whole of the cranium, and the ends fixed by a circular fillet. In performing the second operation, a fine trochar and canula should be inserted one-half inch to one side of the lateral angle of the anterior fontanelle. The fluid should be allowed to run until it stops of its own accord. No pressure nor aspiration should be made. The head should then be strapped to maintain the needed pressure. The parents should always be forewarned of the probable failure of the operation, for the fluid may reaccumulate rapidly, and also of the danger of convulsions and death.

#### Primary Dentition.

The advance of the two incisor teeth in the case I have shown you, have hinted to me that it would be well to occupy the remainder of this hour with a few remarks upon the subject of primary dentition.

You know that normally the human being cuts two sets of teeth, the primary or milk teeth—so-called from their whiteness—and the permanent teeth.

Primary dentition is usually performed between the fourth and thirtieth months. The teeth, in this set, are twenty in number, and are cut in groups, a period of rest occurring between the eruption of each group. The first teeth to appear are the two central incisors of the lower jaw usually at the sixth or seventh month, though at times as early as the fourth. Then there is an interval of from three to nine weeks followed by the eruption of the second group, the four incisors of the upper jaw, between the eighth and tenth months. This is followed by an interval of from six to twelve weeks, when the third group appears, the two lateral incisors of the lower jaw and the four first molars, between the twelfth and fifteenth months. After a rest of twelve weeks, the fourth group appear, the canine or eye and stomach teeth, between the eighteenth and twenty-fourth months, and this is followed by a period of from four to

twelve weeks before the appearance of the fifth group, the four last teeth or posterior molars, by the thirtieth month.

The period of rest is a very necessary and important one. During dentition there is a disturbance of the whole system, and should all the teeth be cut at once the child would be made very ill. Therefore this period is required for recuperation.

The normal plan of eruption may be deviated from. The teeth may be cut too early. I have seen cases in which the first group of teeth was present at birth, while it is not unusual to see them by the fourth or fifth month. Nor is this an unfavorable circumstance, for an early dentition is usually an easy one. It is more apt to occur in children fed from the breast, and in girls than in boys. Next, dentition may be delayed, and the first teeth not appear until the eighth or ninth month, nor the last group before the third year. This delay in dentition should always bring up the question of rickets. It is more apt to occur in bottle-fed babies. Again the teeth may be cut irregularly, the groups not appearing in their normal sequence, or a number may appear at the same time. Delayed and irregular dentitions are both apt to be hard, and to give rise to certain symptoms of disease. The teeth most apt to give trouble are the third and fourth groups, but it is a fact that if one group causes a great deal of trouble, the remainder are apt to be cut without difficulty. The symptoms attending dentition are as follows: When you examine the jaws of a child in whom the teeth are not advancing you will observe that the gums are of pale pink color and have a well-marked ridge-like margin. When the teeth advance this ridge disappears, the gums become swollen, reddened, and moderately hot and tender to the touch. There is some increased salivation and the gum is the seat of moderate pain. These features of the normal process continue until the tooth pierces the mucous membrane, but are never so severe as to cause any disturbance to the child.

In difficult dentition all of these normal symptoms are exaggerated so that we may have catarrhal or aphthous stomatitis, with pain, fever, loss of appetite, and general malaise. Other local conditions are ulceration on either side of the frænum lingue from friction from the sharp edges of the lower incisors and profuse salivation. The latter condition is an important one for it may lead to so much wetting of the gar-



ments as to produce and maintain a severe bronchial catarrh, which, by the way, is apt to resist medical treatment unless the clothing be kept dry by a bib of oil silk or rubber cloth.

The general conditions attending difficult dentition are enlargement of the lymphatic glands at the angle of the jaw, certain eruptions upon the skin, especially eczema, strophulus, and urticaria; vomiting, diarrhoea, infantile convulsions, so-called dental paralysis—the latter being probably a condition of anterior polio-myelitis; blenorrhoea, and otorrhoea are also common complications.

Many authors have denied the connection of these symptoms with the eruption of the teeth, as they regard dentition as a physiological process, and therefore incapable of inducing symptoms of disease. I think, however, there is an undoubted connection, for the interval between the fourth and thirtieth months of an infant's life—the period of primary dentition—is a year of great and widely distributed progress. Not only are the teeth advancing but the follicular apparatus of the stomach and intestinal canal is undergoing development in preparation for the digestion and absorption of mixed food, the cerebro-spinal system is rapidly growing and functionally very active, and the organs and tissues of the whole body are in a state of rapid change. This period of normal transition must also be one in which there is great susceptibility to disease, provided there be a causal influence at work. Such an influence may either originate outside of the body or come from within in the form of some physiological process. Difficult dentition in my mind stands prominent in the latter class.

Whichever of the above symptoms may be present, appropriate medical treatment is of course indicated, but I would especially call your attention to the propriety of lancing the gums over advancing teeth so as to thoroughly free them and do away with backward pressure and consequent irritation of the delicate nervous system. One should not wait until the gums are soft and swollen and until the edge of the tooth can be seen through the mucous membrane but should cut freely down, so as to divide the denser layers of gum and connective tissue whenever any of the complications I have mentioned are present, and examination of the gums shows advancing teeth. The operation is never properly performed unless the edge of the lancet can be felt to grate against the tooth. The incision over incisor teeth

should be linear, over the canines rectangularly crucial, and over the molars obliquely crucial.

## COMMUNICATIONS.

### FLAP-SPLITTING IN PERINEORRHAPHY, WITH SPECIAL REFERENCE TO TAIT'S OPERATION.<sup>1</sup>

BY X. O. WERDER, M. D.,  
PITTSBURGH, PA.

(Continued from page 599.)

The old method of Tait is described as follows, by Edis in his work on *Diseases of Women*, page 445:

"*Tait's Old Method.*—He (Lawson Tait) employs sharp-pointed scissors, running the point of the lower blade through the skin and mucous membrane (along the line c c c), to such a depth as will enable the operator to turn a flap backward from each edge of the rent into the rectum. In making this incision, it is important not to cut at right angles to the vaginal surface, but at a somewhat acute angle to it, so as to bevel the flap outward. The depth of the incision must also be so regulated as not to risk the life of the flap. When the raw surfaces are adjusted and fastened together, it will be seen that these everted flaps form a valve, uninterrupted by stitches, which closes from the rectum, and must, therefore, greatly aid the healing of the wound by preventing the admission of feces. To this peculiarity he attributes very largely the uniform success he has with this operation in a large number of cases. He uses no special needle: either a long-handled curved one, or a common curved needle in a needle-holder, threaded with some of Pearsall's pure silk, which he prefers to wire or silkworm gut. The upper stitch (1, Fig. 9) is first introduced. The needle may be passed from either side into the septum, about an inch from the apex of the rent, and its entrance and exit should always be just at the line of reflexion of the flap (b b). It is passed in the thickness of the septum and brought out within a quarter of an inch of the rent, entered again and passed similarly in the thickness of the septum and out again opposite its vaginal entry.

<sup>1</sup> Read before the meeting of American Association of Obstetricians and Gynecologists in Cincinnati, Sept., 1889.

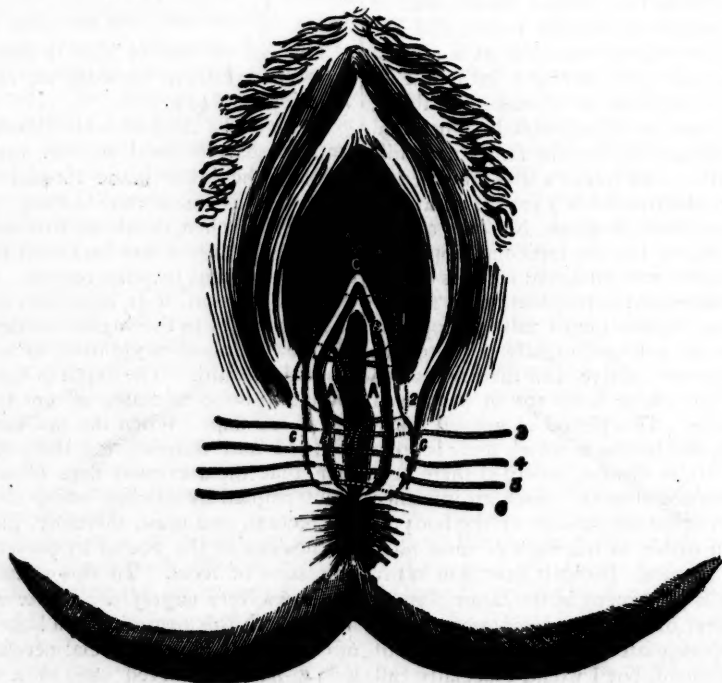
If properly passed it should not, when tightened, be seen or felt either in the vagina or rectum, but should pass between the two mucous surfaces through its whole extent.

"The stitches are not to be tightened, however, until they have all been placed. If necessary, on account of the extent of the cut, a second, similar to the first, should be placed lower down (2). As a rule, one row with the perineal stitches will be enough; indeed, in very many cases the perineal stitches will do all that is required, and septal stitches are needed for bad cases only.

neal stitch is then to be secured and then the posterior, the same precaution with the flaps being taken. The anterior stitches are then to be secured and the ends of all cut off, leaving about half an inch of thread. If the two edges of the incision do not lie quite close together, two or three superficial stitches had better be placed to bring them close."

That there is considerable difference between the operation just described and the new method of perineorrhaphy introduced to the public by Snger, anybody can readily

FIG. 9.



Tait's old method. Complete laceration of perineum.

The perineal stitches should never be less than three in number, and should usually be four. The third (5 in Fig. 9) should be introduced just within the line of the incision on a plane with the septum and its stitches, if there be any.

"All bleeding having been stopped and the wound thoroughly cleansed, the septal stitches are to be first secured, care being taken that the flaps are turned well into the rectum, and not caught in the tightened stitch—this being really the most important part of the operation. The middle peri-

see by comparing the accompanying woodcuts. The difference consists not only in the formation of flaps, but particularly in the introduction of sutures. In the above operation the septum is stitched separately; in the new operation this is discarded entirely, all the stitches introduced being perineal. The new operation is, therefore, undoubtedly an improvement over the old one, not only in its remarkable simplicity of technique, but also in its results.

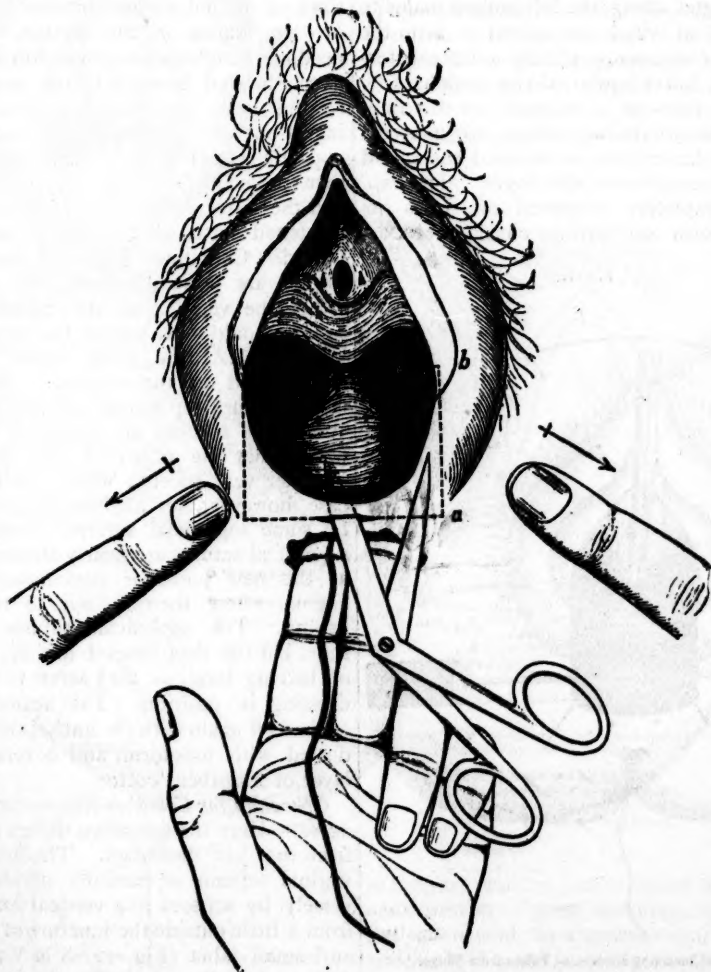
The patient to be operated on is prepared in the usual way, by the administration of

laxatives for several days previous to operation and an enema on the morning of the operating day, or rather several hours before operation. The field of operation is shaved and thoroughly cleansed with soap and water, and then disinfected by a one to one thousand sublimate solution. I generally employ, during operation, irrigation of a one to four

tures, one or two artery-forceps, and an equal number of tenacula, though the latter can easily be dispensed with. This is the whole instrumentarium necessary for this operation.

*Tait's New Operation for Incomplete Ruptures of the Perineum.*—It is well to introduce a tampon of iodoform gauze, with ligature attached, into the rectum, for the

FIG. 10.



Tait's new operation for incomplete laceration of perineum, taken from Slinger.

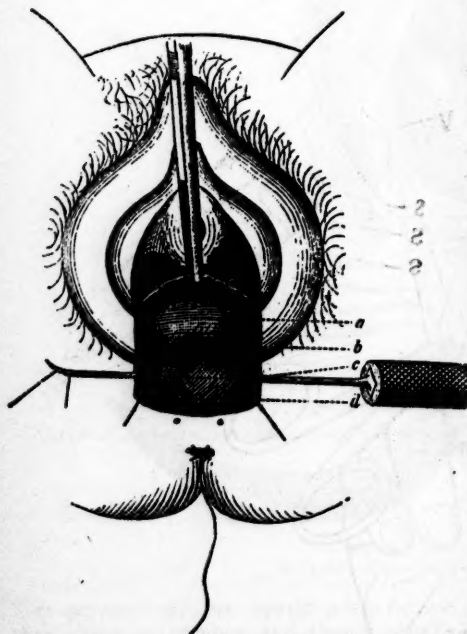
thousand bichloride solution, and in complete ruptures simple distilled or boiled water, or a weak solution of creolin. The legs are held in position by a Kelly leg-holder. The instruments necessary are a sharp-pointed scissors, preferably curved, a long Peaslee needle, an ordinary small curved needle and needle-holder for superficial su-

double purpose of causing bulging out of the posterior vaginal wall, and to prevent the escape of fecal matter during the operation. One or two fingers of the left hand are placed in the rectum in order to steady the vulvar and posterior vaginal wall, then the points of the scissors are inserted transversely (Fig. 10) midway between the



posterior commissure of the vagina and the anus as far as necessary, cutting first on the one side, then on the other side, undermining the whole cicatrix thoroughly to a point met by a straight line drawn from the external border of the juncture of the small and large labia (Fig. 10, *a*). Turning the scissors then from the horizontal to the vertical position (*a b*, Fig. 10), the incision is prolonged along the left labium majus to the point at which we intend to form the posterior commissure, usually a little external to the lower border of the nymphæ (*b*). The same incision is repeated on the other side. The whole flap, which now presents a rectangular outline, is loosened and raised up by a tenaculum or the finger. The flap, when completely dissected off, loses its angular form and shrinks considerably, as-

FIG. 11.



Method of inserting sutures.—(Taken from Säger.)

suming an oval shape. It is lined by skin all around taken below from perineum, and on the sides from labia majora, except, of course, at its seat of attachment, where it is continuous with the vaginal mucous membrane. The bleeding is usually not considerable, and easily controlled by irrigation with hot water; sometimes, however, it is necessary to grasp a few small arteries with the

forceps and twist them. Ligatures are very rarely required.

In regard to suturing material I have followed Säger, who uses silver wire for the deep and silkworm gut for the superficial sutures. Tait himself, it is said, also Mundé and others, uses silkworm gut for all the sutures, others again, prominently Martin, of Berlin, unite the whole raw surface with rows of buried catgut sutures. With one or two fingers in the rectum, a Peaslee needle is inserted about an eighth of an inch from the left border of the wound, and carried under the whole raw surface, bringing it out on a corresponding point on the opposite side (Fig. 11). The silver wire is then passed through the eye of the needle and the latter withdrawn. The wire is not tightened until all the deep sutures are placed. Care must be taken that all the sutures are buried, but do not penetrate either the vagina or the rectum. One suture should pass behind the recto-vaginal juncture—i.e., the place where the flap is attached to the rectum. More than three or four deep sutures are rarely needed. When the stitches are tightened it will be found that the edges of the skin come together very nicely; when this is not the case, however, they are brought into contact by some superficial sutures. One or two superficial sutures are nearly always required at the new posterior commissure of the vagina, where there is apt to be a little gaping. The superficial sutures are cut short but the deep ones I am in the habit of leaving long, as they serve to hold the dressing in position. The wound is now washed off again with the antiseptic solution, dusted with iodoform, and covered with a layer of absorbent cotton.

*Operation for Complete Rupture of the Perineum.*—Here the operation differs very little from that just described. The torn recto-vaginal septum is carefully divided transversely by scissors to a vertical line, drawn from a little outside the juncture of the large and small labia (Fig. 12, S R V; Fig 13, A A, and A B and A B); the incision is then extended up along the labia majora on each side. The vaginal being now finished, the rectal flap is made by carrying the incision downward to each side of the anus (Fig. 13, A B and A B), just outside of the stumps of the sphincter muscle (Fig. 13, C). The whole incision resembles the letter H. Now raising up the vaginal flaps with a tenaculum, and turning down the rectal flaps

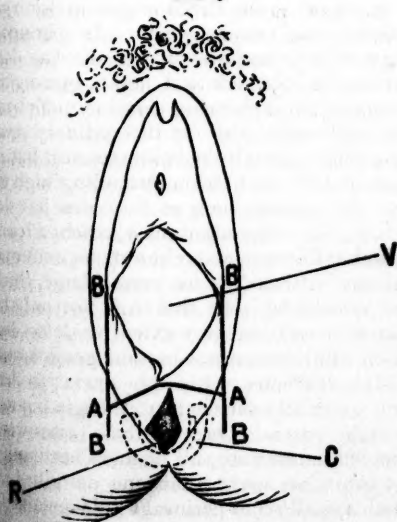
FIG. 13.



Tait's new operation for complete rupture of perineum, taken from Slinger.

into the lumen of the rectum (Fig. 14), the raw surfaces will be found in such close contact as if stitched together. The sutures are introduced in exactly the same manner as previously described (Fig. 14, S S S S), but it is very important that the last suture

FIG. 13.



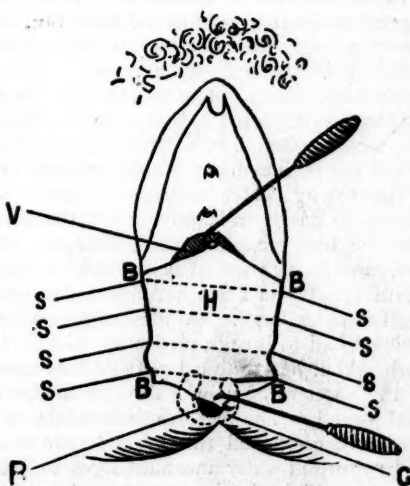
Showing lines of incision.—Made for the author by Dr. C. S. Shaw.

- A A. Incision through recto-vaginal septum.
- B B, B B. Incisions along labia.
- C. Ruptured sphincter ani muscle.
- V. Vagina.
- R. Rectum.

should pass through the torn ends of the sphincter ani muscles (Fig. 14, S B, S B).

The bowels are moved on the third day by a laxative, and unless regular, the laxative is repeated every other day. Only liquid diet is allowed the first few days. Instead of catheterizing the patient I have lately been in the habit of introducing a permanent catheter immediately after operation, consisting of a Skene-Goodman catheter, to which is attached a rubber tube two to three feet long, closed by a stop-cock. This is very convenient when the operation is performed in the patient's house and when no trained nurse is at hand. Even

FIG. 14.



Showing flaps raised and sutures inserted ready for tying.—Made for the author by Dr. C. S. Shaw.

- B B, B B. Incisions along labia.
- C. Ruptured sphincter ani muscle.
- H. Raw surface exposed by raising flaps.
- S S S S S S. Sutures in place.
- V. Vagina.
- R. Rectum.

in hospital practice I have found the permanent catheter of great advantage, as it saves the patient and the attendant much annoyance and, if made perfectly aseptic, there is less danger from cystitis. It does not give the patient any inconvenience whatever; in fact, it was left in the bladder in one case for seven days by mistake without causing the slightest trouble.

The after-treatment consists in changing the dressing of absorbent cotton whenever it becomes soiled, blowing some iodoform on the wound each time. The wound should be irrigated after every motion from bowels

or bladder. Vaginal injections are not necessary. The pain is usually very slight and anodynes are rarely required. The superficial sutures are removed on the eighth day and the silver wire on the fourteenth day. Snger removes all sutures now on the twelfth day and allows the patient to leave the bed. The wound is generally perfectly healed at that time. Occasionally there is a small granular surface at the seat of the wire sutures, which, after they are removed, heals in a few days. In two of my cases a small recto-perineal fistula formed. The first case had uterine prolapse, with cystocele and recto-vaginal fistula, there having been a rupture of the recto-vaginal septum and perineal muscles, leaving, however, the perineal skin intact. An operation for closing the perineal laceration had been done fifteen years ago, leaving a recto-vaginal fistula which had remained open ever since. I amputated the cervix, made an anterior colporrhaphy, using buried catgut sutures, closed the recto-vaginal fistula with catgut and restored the perineum by Tait's method, all at one sitting. Her bowels were moved on the fourth day by a laxative. On the sixth day she had great tenesmus, sitting on the bed-pan all day without being able to pass anything. When I saw her late in the evening I found a large, hard mass in the rectum which I had to break up with my hand. In washing out her rectum I noticed that some of the water was escaping through the perineal wound. The recto-vaginal fistula had evidently re-opened through her straining and permitted water and fluid feces to pass through. This fistula closed up, however, in a short time, and the result of the operation was very satisfactory.

The second case was an extremely unfavorable one for operation. There was not only a rent extending from two to three inches up into the rectum, but the rectum was prolapsed, protruding about two inches when the patient was in the horizontal position, but when on her feet or in the act of defecation it came down certainly six or seven inches. The rupture had existed for at least fifteen years, and during the last six months locomotion had almost become impossible. In order to make the flaps sufficiently large to cover the defect and to prevent their sloughing, the incisions were made very deep both up the vagina and into the buttocks. In this case a recto-perineal fistula formed because one of the silver wire sutures, of which there were seven, broke.

Though at the last examination, about two months after the operation, there was still a small fistula present, it had contracted so that no fecal matter escaped through it. In order to retain the bowel and to secure it against prolapse, after returning the bowel to its normal position, I passed one of the silver sutures through the external coat of the rectum. The patient has almost complete control of her bowel now and there is not the slightest tendency to prolapse. Physically the patient is now perfectly well, but her mind, which was slightly unbalanced before the operation (due, as we thought, to her wretched condition), is now entirely deranged, so that her transfer to an insane asylum became necessary.

In my first operation I followed Snger's advice to insert the sutures exactly at the edge of the wound, but within the wound surface. But I have found that when the sutures were tied the skin borders became slightly separated, requiring a number of superficial sutures to keep them coaptated. In the subsequent cases, therefore, I inserted the needle just within the skin, about one-eighth inch outside of the borders of the wound, thereby causing more accurate coaptation of the wound surfaces. If too much skin is caught within the stitches, it is apt to roll in, thereby preventing primary union.

In regard to the depth of the incision no definite rule can be given. In perineorrhaphy for incomplete rupture the flap does not need to be thick and fleshy, one-eighth to one-fourth inch being certainly sufficient. This will suffice also for the ordinary complete rents through the sphincter ani, but in cases of very deep tears extending high up into the rectum, such as the case just described, the dissection must reach a considerable distance above the rectal rent and into the buttocks, as we need a large, thick and bloody flap, one that will not only be able to cover the very extensive defect but which will live and not become gangrenous.

My experience with this operation has been extremely satisfactory, though limited to eight cases. Three of these cases were complete lacerations, all of them healing by first intention except the one described in which a small recto-perineal fistula remained, now rapidly closing up, however. The results have been perfect in each case, as also in five cases with incomplete ruptures. One of these was complicated with recto-vaginal fistula of long standing, which I sewed up



with catgut before performing Tait's operation. Zweifel and Sanger each report one case of fistula, for which no extra treatment was used, and both of which were cured permanently by Tait's operation for the repair of the perineum. In one case I amputated the cervix and performed anterior colporrhaphy at the same sitting. In two cases I performed trachelorrhaphy and in one trachelorrhaphy and curettement of the uterus.

Sanger reported at the last meeting of the German Society of Gynecology, at Freiburg, seventy-one operations performed according to this method, ten of which were complete ruptures, none of which failed. Howard A. Kelly closed up a complete rent which had been operated ten times unsuccessfully, by Tait's new method with an excellent result. P. F. Munde operated seventeen times, eight complete and nine incomplete ruptures, with a perfect cure in each case, except one, which, strange to say, died from septicemia. In the *British Gynecological Journal*, August, 1889, Fancourt Barnes gave a complete history of twelve cases of complete laceration of the perineum operated on by Tait's new method, in all of which perfect cures were obtained. I might add the reports of many other operators, but I think this list will be sufficient to convince the most inveterate sceptic of the efficiency of the operation.

There is certainly no operation that can compare with this in simplicity, celerity of performance, and uniform success. For complete ruptures I regard it as the ideal method which, in my opinion, is destined to rapidly supersede the old triangular operations which so often fail. In this operation the success does not depend, as in the triangular methods, on the behavior of the sutured vaginal and rectal mucous membrane; but, to use Sanger's words, "on the rapid, certain, and firm cicatrization of the perineal skin." The occurrence of recto-vaginal fistule, so common after the older methods, seems impossible after this operation. Should primary union of the perineal wound fail to take place at certain points, this will not mar the success of the operation, as, especially when the posterior vaginal commissure and the sphincter ani muscles have united, secondary union will always take place. Even a total failure would at least not increase the trouble, as no tissue has been removed, and the parts simply remain *in statu quo*.

## MEMBRANOUS CROUP AND DIPHTHERIA.

BY P. J. FARNSWORTH, M. D.,  
CLINTON, IOWA.

Charlie W., seven years old, came home from school complaining of symptoms of a common cold; coughing a little as if from bronchitis, but saying nothing of sore throat. Ate his supper and after a little time went to bed, his mother getting him warm and tucking him carefully in. About three in the morning the parents were aroused by the cries and brassy cough of the child. The mother suspected croup, and put a cloth wrung out of cold water around the neck and made some hot tea of summer savory, which he drank, also taking a half teaspoonful of *Hive* syrup (*Tr. scilla, Com.*), which produced vomiting and relieved the paroxysm, and he fell asleep. At nine or ten in the morning he had an attack of coughing of the same croupy character and again at intervals during the day. At night soon after going to bed, he roused up with the same brassy cough and considerable dyspnoea. I was called at once, and found the boy in a high fever, but breathing without much difficulty, and somewhat hoarse. I examined the lungs, but did not find any serious rales or crepitation. Examination of the throat only revealed a little irritation. Waiting a little before prescribing, all at once the peculiar brassy ringing cough came on and considerable spasm of the glottis was noted. It was unmistakably membranous croup. An emetic of ipecac relieved the paroxysm, ice cloths were applied to the neck and inhalations of steam from an atomizer used.

There was no prostration and the fever soon subsided. A solution of potassa iodide was given in doses of ten grains every two hours. The paroxysms increased and by the next night breathing was labored, the cough more frequent, the voice nearly lost; still no membrane could be discovered in throat. With the assistance of a neighboring practitioner we introduced a tube into the larynx. The boy was docile and assisted us as much as possible and the tube was placed without much difficulty. It relieved the breathing for a little time, then seemed to add to the distressing symptoms and was removed. Stimulants were then tried, but no great amount was taken. Dilute alcohol was given in spray form. Cal-

omel in five grain doses every two hours had been given. It was all to no purpose, and towards morning of the third night breathing became so labored that it finally stopped. We did not try tracheotomy, and could not get a *post mortem*.

Several physicians were called in to see the case. Some of them had never seen one like it. Some of the older ones called it membranous croup at once. Several were attending cases of diphtheria and had often seen cases of diphtheritic croup, but none with symptoms like this.

It did not become a constitutional disease, nor was it so at first. It began in the larynx; membrane did not make its appearance in the fauces. There was no great amount of fever except when the paroxysm was on; there were intervals of what seemed to the casual observer total abatement of the disease. The cough appeared suddenly and with the true croupy ring, which if once heard is never forgotten. There was no affection of the lymphatics. It may be said that there was not time, but in croupous-diphtheria the lymphatics are invariably enlarged, and there are other signs of septicemic poisoning. There was no fetor of breath, which is characteristic of diphtheria. Without enumerating the negative symptoms of diphtheria, which was prevailing in another part of the town, the difference was so marked that all who saw the case declared at once that no mistake could be made in the two diseases.

Membranous croup is not a common disease. No genuine cases have been observed in this locality for six years, and then only one or two cases were reported. Physicians of twenty years' practice stated that they had never seen a genuine case before. For this reason, the rarity of the disease, so many practitioners declare the diseases identical, when probably they have never seen a case of genuine membranous croup.

In 1860, being a student in New York, I saw several cases of well-marked diphtheria, just then beginning to prevail. Observed it well and listened to lectures on the subject. In the second year of my practice I saw four cases of membranous croup; three of them died. The next year we had many cases of diphtheria of which only one died out of twenty. Since then I have passed through some severe epidemics of diphtheria, in one of which forty cases were fatal out of a hundred. Of genuine croup I have not seen more than ten cases in twenty-five years,

since the second year of practice. It seems less frequent than formerly. In some of the records of the old practitioners, say during the first half of this century, cases of membranous croup were numerous and the disease seemed epidemic; these cases may have had diphtheria, but the descriptions are so clear, that it seems hardly possible. Diphtheria undoubtedly did occasionally occur, for as early as 1680 a New England clergyman speaks of a malignant sore throat that prevailed at the time that is described in many of the terms of diphtheria, and at several other later periods it was described but disappeared again, so that up to about 1858 old practitioners had never seen the disease. Since then there are few, unfortunately, that are not familiar with it.

Membranous croup is confined to children, and the percentage of death is very large; eighty per cent. or five out of six die, under any treatment yet devised. Inhalations afford relief, and lime water dissolves the membrane. Mercurials, theoretically, should arrest the disease, but time is seldom given for the drug to get its full effect. Tartrate of antimony is worse than useless, and emetics only occasionally dislodge the membrane. Tracheotomy is sometimes successful; intubation has promised relief, but is of doubtful utility.

A case occurred in my own family in which a large amount of gin seemed to be the remedy. The little one was three years old, and had been incautiously exposed to the winds of March, with insufficient clothing on. In the night we were aroused with the dreaded cough. It might be pseudo-membranous, so an emetic was given, which gave temporary relief, but with day the fearful ringing sound was heard and the paroxysms increased towards night. A perusal of the literature on the subject is a meditation on death, and, in previous experience, all the routine remedies had been tried without success. Iodide of potash suggested itself, from its effect on spasmodic asthma, and seemed to give some relief. There was considerable depression of the heart's action at times and some alcoholic stimulant was prepared, which happened to be some cordial gin having a pleasant bland taste. An ounce or more was reduced with an equal amount of water and simple syrup, with directions to give a teaspoonful occasionally. The child was thirsty, and the mother mistaking the grog for water gave the child an ounce of the mixture. Relaxation

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seemed immediately to take place, the paroxysms of coughing seemed softened, and the breathing relieved. More of the remedy was given, and evident signs of alcoholic intoxication were soon apparent, which were kept up for three or four hours by all of the drink the child would take, which amounted to as much as three ounces of the compound. An emetic was then given, and the membrane came up in long shreds with the superabundant alcohol. Sleep followed at once, with easy breathing, and a speedy recovery with little apparent prostration followed. That was six years ago, and the one described in the first part of this paper is the next one that has occurred in my practice. In the last case the iodide seemed at first to mitigate the disease, but the mercurial that followed produced no effect, and it was impossible to induce the child to take alcohol enough in any form to produce its impression.

The alcohol treatment has been tried with some success in diphtheria, with patients that were more manageable than children, and there is some hope that it may prove efficacious in certain cases of that disease. In diphtheria the fatal issue is produced by heart failure, exhaustion, paralysis and by suffocation, and stimulants may avert some of these symptoms. In croup they die, as a rule, from suffocation.

## SOCIETY REPORTS.

### OBSTETRICAL SOCIETY OF PHILADELPHIA.

*Stated Meeting, October 3, 1889.*

DR. THEOPHILUS PARVIN in the Chair.

DR. E. P. BERNARDY reported a case of

#### Post-Puerperal Hematocele,

for which he operated successfully. The patient was thirty-eight years old. Four days after a normal, but somewhat tedious, labor, the patient complained of a sense of fullness of the abdomen. She also had constipation, and could not pass her urine. Examination by the rectum showed a tumor about the size of an egg, and vaginal examination revealed a tumor behind and to the left of the uterus. The tumor rapidly enlarged, and in a week filled the entire pelvic cavity, pushing down to almost the

external sphincter. The entire left side of the pelvis was completely filled by the growth, which pushed the enlarged uterus well to the right side, making it appear as if there were another tumor. Operation was advised and was performed five days later. The usual medium abdominal incision was made; on introduction of the finger in the abdomen, the entire left side of the pelvis behind the uterus and broad ligament was found filled by a tumor which was surrounded by adhesions which were readily separated before enucleation. In passing the finger behind the right side of the uterus, the finger ruptured some slight adhesions, entering a cavity from which freely flowed thick blood, looking and smelling like blood contained in an extra-uterine sac. After enucleating the left-side tumor, an immense cavity was left, which was, as well as the abdominal cavity, well doused with hot water; both ovaries and tubes were healthy, and were not touched; a glass drainage-tube was introduced, and the abdomen closed. On the sixth day, glass drainage-tube changed for a rubber-tube. Three days later this tube was taken out and the stitches taken out the sixth day. Eighteen days after the operation the wound had entirely healed up, and the patient soon after was allowed to go home.

DR. H. H. KYNETT reported a case of double pyosalpinx and double ovarian abscesses; a case of double hydrosalpinx and left ovarian cyst, and lastly a case of tumor of the breast, which he believed to be a milk cyst. All three cases were operated upon successfully.

DR. W. L. TAYLOR then read a paper on the removal of a large

#### Ovarian Cyst,

followed by rupture of the right common iliac vein. The patient was twenty-four years old, and very much emaciated; her abdomen enormously extended. A lump had appeared in the right side of abdomen about two years ago which never caused any pain, but only a sense of discomfort from pressure, and with rapid increase in size.

Upon examination, the abdomen gave evidence of the presence of a very large encysted fluid, ovarian in character. On July 7, Dr. Taylor operated and removed a non-adherent cyst of the right ovary. The fluid of the cyst was syrupy and very heavy, weighing fully fifty pounds. The pedicle



was unusually thick and was tied in sections, and finally with a Tait ligature. The steps of the operation were devoid of special interest, and but little cyst fluid or blood escaped into the abdominal cavity. The latter was thoroughly washed out, and the absence of bleeding-points was remarked. Noticing a slight oozing of blood from the region of the pedicle, the operator investigated, and found that a couple of veins, which were greatly distended, had ruptured just beneath his ligatures. These were tied securely, and whilst doing this he noticed higher up—fully as high as the sacro-iliac juncture, and to the right side—what appeared like an adherent intestine, rapidly distending, with a central portion most distended. This rapidly thinned out, and gave every appearance of speedy rupture. Touching it gently with his finger, it burst instantly, and there was a frightful gush of blood. The bleeding vein, for such it proved to be, was quickly grasped and then caught with a large Pean forceps, which imperfectly controlled the hemorrhage. Then the vein was separated from its artery and ligatures carried securely around it. These immediately stopped all hemorrhage, but caused a very decided and alarming venous swelling on either side of the ligatures. The wound was then closed up after introducing a drainage-tube. At the close of the operation, the patient's pulse was 160, the temperature sub-normal, and the respiration about 40. Everything certainly pointed to a positive recurrence of hemorrhage, and she was most carefully watched.

In the discussion which followed,

DR. WILLIAM GOODELL said that this seemed to be an unique case. He had never seen anything like it in simple unadherent cysts. In intraligamentary cysts he had often torn deep-seated veins, and had had difficulty in checking the hemorrhage.

DR. J. PRICE said that he thought that there was great danger of wounding the vein by the use of the Baker, Brown or Peaslee needle. These accidents have occurred from traumatism, from manipulation, and wounds made by the use of instruments.

DR. W. L. TAYLOR said that the hemorrhage occurred long after any traumatism could have happened, and was so much higher than the pedicle, that he thought it could not be attributed to traumatism. The hemorrhage was spontaneous. It did not occur gradually, but there was a sudden

gush of blood following the touch of his finger.

DR. THEOPHILUS PARVIN then read a report of a case of

### **Tubal Pregnancy,**

probable diagnosis, and removal prior to rupture.

This patient was brought to the hospital of Jefferson Medical College, September 19, suffering from a probable ectopic gestation. Upon examination, Dr. Parvin found a tumor adjacent to the uterus upon the left side, the uterus was somewhat enlarged, and very sensitive to pressure, as was also the vagina and the lower part of the abdomen. The history, the examination, and the previous examinations of Dr. Baldy, with his conclusion, left but little doubt that the case was one of tubal pregnancy. Abdominal section was done on the 20th of September, Dr. Baldy and Dr. W. E. Ashton assisting in the operation. The gestation cyst included in the tube was removed. The patient's convalescence has been uninterrupted.

DR. J. M. BALDY reported a case of

### **Tubal Pregnancy, no Diagnosis, but Removal Prior to Rupture.**

The patient (colored) had walked into the out-patient clinic of the Howard Hospital, July 5, 1889, suffering from pain in her abdomen, so similar to that which I have often seen go with a pyosalpinx, that I diagnosed this disease before examining her. The examination revealed a large, apparently tortuous, tender mass, posterior and slightly to the left side, giving a boggy feel to the touch. The diagnosis was verified, a saline purge given, and an immediate operation advised.

One week later, a messenger summoned me to the home of the patient, where I found her lying on the bed, suffering from severe pain in the abdomen. A re-examination of the pelvis showed only what had been before found; viz., a cystic mass, which did not pulsate, posterior and to the left; apparently a distended tube. The uterus was in position of normal ante flexion, and there was a perfectly normal cervix for a multipara. There was an elevation of temperature, and the woman had had chills. It was decided that it was a case of pyosalpinx, at the same time ectopic gestation was thought a possibility, but sufficient data on which to verify this suspicion were not found. The abdomen was opened the next day with the

assistance of Drs. Hamill and Naylor, and a left tubal pregnancy removed. The case well illustrates the difficulty, nay impossibility, of at times diagnosing ectopic gestation. In three weeks the patient was sent home and is to-day in her usual good health.

DR. E. W. CUSHING, of Boston, said that the subject of extra-uterine pregnancy is one of great interest to him, and he could say, from sad experience, that it is not easy to make a diagnosis. After some obscure symptoms of irregularity of menstruation, etc., a near relative was taken suddenly with a severe attack which, after the event, he felt was due to a tubal pregnancy ruptured into the broad ligament; she finally recovered without operation. In another case a physician operated for an ill-defined tumor. The cyst was opened after the operation, and a fetus three-fourths of an inch in length found. There had not been a suspicion of pregnancy.

DR. WILLIAM GOODELL said that in regard to the electrical treatment of extra-uterine fetation, he was theoretically inclined to believe in it. But when he had met with cases of extra-uterine fetation, and saw the mass that was present, and the adhesions and injuries which adjacent organs had sustained, he could no longer uphold it. He had practically been converted to the belief that electricity, and particularly electrolysis, should not be used in these cases. The electrolytic action is a most dangerous one. Although advocated by Apostoli, the results have been most disastrous in the cases in which it has been tried. He had had four cases of early extra-uterine pregnancy within a few months, all of which were successful. He believed that Tait was correct in explaining advanced cases by the rupture of the tube and the escape of the unbroken gestation sac into the fold of the broad ligament. The behavior subsequently is precisely like that of an intraligamentary ovarian cyst.

In regard to early diagnosis, he should say that the most common symptom is arrest of menstruation for one or two periods, followed by irregular uterine hemorrhages. It is true that pelvic colic is a common symptom, but not so common as the other.

DR. BARTON C. HIRST said that some time ago he was called to a case in consultation which presented a clear history of extra-uterine fetation; cessation of two periods; hemorrhage with the discharge of deciduous membrane; a distinct tumor to one side of the uterus, and the subjective

signs of pregnancy, with swelling of the breasts and vomiting. Dr. Hamill and myself urged operation, but the family being dissatisfied, we were discharged. Another physician was called, and Dr. Parrish was consulted. He recommended the use of electricity, and a current was applied with relief of the symptoms, and complete cure of the patient. There might have been a varicose vein in the broad ligament which having burst may present all the signs of extra-uterine fetation after rupture of the sac.

DR. M. PRICE had seen twenty or twenty-five cases of extra-uterine pregnancy, nearly all of them ruptured tubal pregnancies. It does not interest us a particle whether the cases were diagnosed or not. There is trouble present of such a serious character that it does not become us to lose a single moment. Most of these cases come into the coroner's and not the surgeon's hands. Delay in operating is adding ten per cent. to our mortality. It is our duty to operate on the first indication, and if we are mistaken, to thank God for the absence of so serious a condition.

DR. JOSEPH HOFFMANN had twice operated for extra-uterine pregnancy and did not find it, and had operated for something else and found extra-uterine pregnancy. The first case presented the signs of extra-uterine pregnancy to even a more marked degree than that of Dr. Hirst,—coming on after a sterility of eight years, a retroverted mass, flooding and violent pain. At the operation he found two pus-tubes. In the third case he operated for pus-tube and found extra-uterine pregnancy.

DR. NOBLE said that a short time ago he removed an extra-uterine pregnancy which was rather unusual in the conditions present (see MEDICAL AND SURGICAL REPORTER, November 16, 1889). The patient was seen by Dr. Kelly, and it was agreed that it was almost certainly an extra-uterine pregnancy.

DR. B. F. BAER said that he wished to go on record as one who believed that it is as easy to diagnose extra-uterine pregnancy as to diagnose any other condition within the abdomen (as hydrosalpinx or pyosalpinx) positively.

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IN GERMANY the Government has come to the conclusion that there are enough medical colleges in the country and refuses to allow any more to be organized.

PHILADELPHIA COUNTY MEDICAL  
SOCIETY.

*Stated Meeting, October 23, 1889.*

The Vice-President, JOHN B. ROBERTS,  
M.D., in the Chair.

DR. JOHN B. ROBERTS presented a paper  
entitled

**Extraction of Cataract.**

In giving a brief outline of the steps of the operation, Dr. Roberts said that in preparing the patient for operation, he cleanses the face in the vicinity of the eyes with soap and water, and subsequently with a solution of boric acid or corrosive sublimate. He then washes out the conjunctival sac with a boric acid solution instilled with an ordinary pipette. A few drops of four per cent. solution of hydrochlorate of cocaine is dropped into the eye two or three times during the quarter hour preceding the operation. A few drops of a four-grain solution of atropia is also instilled. The steps of the operation are as follows: Having grasped the conjunctiva and the inferior rectus with a pair of fixation forceps, an upward incision of the cornea is made with a Graefe, Beer, or Jackson knife.

The iridectomy is accomplished by catching and drawing out the iris with an iridectomy hook in the left hand, and cutting it with the Levis spring scissors in the right hand. He does not use the iris forceps for the iridectomy unless it happens that, for some reason, a portion of the part excised has not been perfectly detached from the iris. He then uses the forceps to catch the ragged edges while making a second attempt at complete division. Laceration of the capsule is done by making a T-shaped incision with a cystotome. The lens is then extruded by pressure upon the sclerotic and cornea, with the finger above and a tortoise-shell scoop below the incision. The finger makes the pressure from the outside of the upper lid. If there is any difficulty, as there often is, in evacuating the soft cortical material or nucleus, the spoon is introduced and the remnants extracted. After a few minutes have elapsed to allow reaccumulation of the aqueous humor, the patient is allowed to sit up with his back to the light, and a convex lens of about nine dioptrics is placed before the eye which has been operated upon in order that the patient

may be convinced that vision has been restored.

After instilling a few drops of atropia solution the eye is sealed by means of two or three small strips of ordinary rubber plaster upon the upper lid. These strips of plaster are cut in the shape of a semi-ellipse, and are made to fit the upper lid, but under no circumstances are they to overlap the lower lid. In this manner the upper lid is made stiff and acts as a splint to the wounded cornea.

The advantage of this method is that the eye is not heated, and tears and mucus can drain from between the eyelids, and atropia solution can be introduced into the conjunctival sac every morning or evening, as the surgeon may deem proper. Before the operation it is best to cut off the eye-lashes of the upper and lower lids, to prevent the eye becoming sealed by dried secretion upon the lashes, which gives the patient pain, and has a deleterious effect upon the eye by interfering with the free flow of tears and mucus. As a rule, only the eye which has been operated upon is closed, and the patient is not restricted to a dark room, or confined to bed.

In the discussion,

DR. GEORGE C. HARLAND said, that the points of most interest at the present time, in connection with this operation, are: the after-treatment, the use of antiseptics, and the performance or non-performance of iridectomy. There is no doubt that the after-treatment has been much modified of late. The patients are not kept so long in bed, and the dressings are much simpler. He thinks it well to use the bandage for two days, and to keep the patient in bed two or three days. As boric acid has been shown to be without antiseptic qualities, he has abandoned it, and now uses bichloride solution, 1:5000. Even in this proportion it causes some irritation of the conjunctiva. The question of iridectomy is now the great point of discussion. There is a strong party in favor of omitting iridectomy in the operation for cataract. There are æsthetic and perhaps optical considerations in favor of a round pupil; but this advantage, which has been somewhat exaggerated, is dearly bought at the expense of the greater difficulty in accomplishing delivery of the lens and the removal of cortical *débris*, and particularly of the risk of prolapse of the iris. Alfred Graefe, at last year's meeting of the Heidelberg



Society, said that he had allowed himself to be bewitched by the round pupil, but that prolapse of the iris had disenchanted him.

DR. B. ALEX. RANDALL said that he had thus far done iridectomy in all operations, as it facilitates egress of the lens. A small removal of tissue is generally sufficient; and, after it, he has secured a perfectly mobile pupil, almost as round and perfect for visual purposes as though no iridectomy had been done—the coloboma being thoroughly covered by the upper lid. Dr. Randall emphasized the point that cocaine must be used with caution, since it affects the nutrition of the corneal epithelium: and our studies show that it is largely upon this epithelium that the healing process depends.

DR. MORDECAI PRICE then read a paper on

### Ectopic Gestation.

He said, in order that ectopic gestation may be possible, the tube must be diseased, its lining membrane removed, its ciliated epithelium no longer urging the product of conception onward to its natural abiding-place nor retarding in the least the spermatozoa from intruding on dangerous and forbidden ground. This condition is brought about, he believed, in fifty per cent. of the cases by gonorrhoea, and the remainder by cold, and septic conditions following child-bed and catarrhal affections from other causes. That the pregnancy in the beginning is always tubal is well proven, from the fact that the tube is the only portion outside the uterine cavity offering the conditions favorable for impregnation. The product of conception thrown into the peritoneal cavity either at the time of impregnation or during the first few weeks of gestation would undoubtedly be digested. We have the best proof of this in the fact that in early ruptures into the peritoneum of only a few weeks, no fetus can be found; only the blood clot, the diseased tube and membrane remaining. Those cases that have advanced to maturity in the peritoneal cavity have without doubt been those first developed in the tube, and then ruptured in the broad ligament, and when able to resist the digestive fluids of the peritoneum, the secondary rupture has taken place.

Tubal pregnancy would be of but little moment to us, if it were not for the fact that most patients are not aware there is anything wrong. If they suspect pregnancy at all they have no reason to doubt that it is the usual old-fashioned kind, and the

first warning, alike to patient and doctor, is rupture of the tube, with symptoms of internal hemorrhage—often so serious that the patient lives but a few hours. These cases are far more numerous than is supposed—in this city alone about twenty-five a year. Five years ago the mortality was one hundred per cent., and now at least ninety per cent. are saved. The symptoms of ectopic gestation before rupture are of a vague and uncertain character.

In most cases of ectopic gestation in his own hands, the diagnosis was made before operation. Rupture had taken place in every case. Diagnosis of tubal pregnancy before rupture would simply be a happy guess.

In the discussion which followed,

DR. A. J. DOWNES said that while in Atlantic City, a year ago, he was hastily called to see a woman in collapse. There was great abdominal pain. She had had two attacks of pain and collapse on the day before he saw her. At 10 A. M., she had another attack, and at 11 o'clock he saw her. In the afternoon she had a fourth attack and died. The point he wished to raise was, whether after the third collapse, with the abdomen filled with blood, a surgeon could go in without trained assistants, with a prospect of relieving the patient.

DR. JAMES COLLINS remarked that in an emergency, a surgeon who knows his anatomy, who knows how to tie a knot and keep his head level, is justified in doing anything. He should stop the bleeding if he is sure of his diagnosis.

DR. J. HOFFMAN said that it was unfortunate that some of the advocates of early diagnosis were not present. A case has recently been reported where it was claimed that a five months' fetus was melted away. Such a thing as that is impossible. He had twice operated expecting to find extra-uterine pregnancy, but failed to find it. Once when operating for something else he did find it.

DR. J. PRICE said that the course of surgeons in the treatment of this condition is well grounded. It is our duty in cases of hemorrhage to seek the offending vessel and secure it.

The diagnosis of early tubal pregnancy cannot be made from the physical signs. The history and symptoms with the physical signs often make it highly probable that we have to deal with ectopic gestation, but that is about all that we can say.

## PERISCOPE.

### Removal of Plaster of Paris Dressing.

Dr. Charles H. Richardson, of New York, describes, in the *Medical Record*, November 16, 1889, a way of removing plaster dressings as follows: I have used of late a plan in the removal of plaster and starch bandages which seems to do away with the annoyance to the surgeon, and the discomfort, not to say distress, to the patient, attending removal by the shears. It consists simply in the application of a piece of wire under the bandage, which is made to cut its way out when removal of the apparatus is desired. The limb is prepared for the bandage in the usual manner, either by the application of a flannel roller or by being well anointed with vaseline. A fine steel wire is then laid the length of the limb, in the situation that it is desired subsequently to cut, and firmly held in that position by an assistant. This is secured by a few turns of the plaster bandage, and the apparatus finished in the ordinary way. The wire should project four or five inches at each end of the bandage, so as to afford sufficient for a firm hold when the time comes for removal. These free ends of wire may be bent down after the casing is completed, to prevent the annoyance to the patient which the sharp ends might otherwise produce.

When the removal of the appliance is desired it is necessary to have the patient rest his limb on a table in order that it may be perfectly steady, and while the lower projecting end of wire is held firmly in place, to prevent its slipping underneath the bandage, the upper end is seized by a pair of pincers and by firm traction made to cut its way through the whole length of the casing. The apparatus may now be bent back and removed, the operation having caused no discomfort, which can hardly be said of the combined prying and cutting with a pair of plaster shears.

He calls attention to two points: the first is that no attempt should be made to remove the casing until it is completely and entirely dry, as the wire will not cut through wet bandage. The second is, that while one wire will cut through the ordinary light dressing, such as is used on the arm, yet when an extra thickness is given to the apparatus, as in a plaster acket or in an appliance to the lower limbs,

I would recommend that two or even three wires be used, to make the cutting easier and more sure. If more than one wire be used, the second is laid as nearly over the first as possible, after a few layers of bandage have been applied, and a third over this if it be deemed necessary. Thus a layer of plaster and bandage will intervene between each of the two or three wires. The method of cutting is evident. It is done in sections, by pulling the wires in inverse order to that in which they were laid.

### Intussusception at Three Years of Age, Successfully Treated by Rectal Injection.

Dr. John W. Farlow reports in the *Boston Medical and Surgical Journal*, November 4, 1889, the following instructive case.

N. R., a three-year-old boy, had always been well, I saw him March 7, with the story of having been somewhat under the weather. His mother had given him castor oil, which produced four or five loose stools. I saw him in the morning, and found him crying at intervals and putting his hand near his umbilicus. The anus was rather relaxed and he passed a little blood and slime from time to time. Nothing was felt in the abdomen. At 4 P. M. the pain had increased and was paroxysmal; at 9 P. M. the same condition, only more pain. The next morning early I found that he had slept some in the night, but since six o'clock he had cried and thrown himself round on the bed and over on to his face. He still passed blood and slime, but no feces. He kept putting his hands near the umbilicus and said the pain was all there. To the left of the umbilicus a very marked fulness could be seen, the lower part of which was dull and rather firm, while the upper part was tympanitic. The diagnosis seemed assured.

The boy was inverted and his feet held up high. By means of a Davidson's syringe I injected slowly into his rectum one and one-half pints of luke-warm water, at the same time trying to press back the tumor from the outside. The child only cried the harder. About fifteen minutes later he got up and passed the water. Nothing but a little blood came with it, but on getting back to bed he stopped crying, and from that moment the pain entirely ceased and the tumor was no longer felt. The case was uneventful after that. He had a fair stool

March 17, three days after the intussusception was reduced. I have seen him several times since, and he continues in good health.

### Foreign Body in the Trachea.

In the *Virginia Medical Monthly*, November, 1889, Dr. E. W. Row, of Orange, Va., reports an interesting case of grain of corn in the windpipe of a boy four years old. After eating parched corn one day he had cough and dyspnea which were partly and temporarily relieved by an emetic of apomorphia. About midnight, however, the symptoms returned with increased severity, and a foreign body could be felt moving in the trachea. The next morning tracheotomy was performed, and a large grain of corn was taken out of the windpipe. The child then recovered promptly.

In reporting this case, Dr. Row recalls a similar case, which he attended about thirty years ago, in which operative interference was not permitted by the family, yet the little patient continued to live, although he became reduced to almost a skeleton. He was finally relieved by nature, abscesses having formed and ruptured into the bronchus, washing out the grain of corn. This patient, after daily expectation of death, for more than a month, recovered. In commenting on these cases, Dr. Row says that in all cases where foreign bodies are suspected in the air passages, notwithstanding the dyspnea and threatened asphyxia may, for the time, be partially relieved by relaxing remedies, yet, it is the imperative duty of the surgeon to watch the case closely, and to apprise the patient's friends of the probable alternative, so that both he and they should be fully prepared if finally operative interference is demanded. With respect to diagnosis of bodies in the windpipe he believes, when it is not impacted, the foreign substance can be easily felt in the trachea as it passes along that tube in the up and down movement caused by respiration; and also that a foreign body may be detected by auscultation, by the rapidity of the movement and suddenness of the "thud" (so to speak) when compared with the movement of mucus in the tubes. The impression of the latter upon the ear is more diffused, does not start so suddenly, pass so quickly, or stop so abruptly, and without a distinct "thud" before reversing its motion. He also suggests that chloroform is

not contra-indicated in partial obstruction by a foreign body in the air-passages, where a great factor in the production of symptoms threatening asphyxia is dependent upon spasmodic muscular contraction.

### Abscess of the Antrum.

A new diagnostic sign of abscess of the antrum was brought forward by Dr. T. Heryng, of Warsaw, at the Congress of Otolaryngology and Laryngology, held at Paris during September. The patient is placed in a dark room and his mouth lit up with a small electric lamp, placed above the tongue. Two bright red spots will then appear below the lower eyelids.

If the cavities are filled up with pus, or occupied by a tumor, these red spots will not appear, but as soon as the pus escapes or the cavity is washed out, the spots again become visible.

### Cough Syrup.

The following is said to be an excellent remedy for convulsive coughs:

Sodium benzoate . . . . .	5 parts
Mint water . . . . .	40 parts
Distilled water . . . . .	40 parts
Syrup of orange peel . . . . .	10 parts

Mix. Dose, a teaspoonful may be taken whenever necessary.—*National Druggist*, Nov., 1889.

### The Vitality of Trichinæ.

In the year 1882, Professor Pasteur and Professor H. Bouley conducted a series of experiments regarding the vitality of trichinæ in ham. At that time it was discovered that the trichinæ lived even after having been exposed to a temperature of 32° (Fahr.).

Quite recently these experiments have been resumed and it was discovered that the trichinæ were more active in fresh pork than in cured ham. It was also proved that their vitality was in no wise decreased after an exposure of several hours to a temperature considerably below freezing point. High temperatures, up to about 80°, seemed to agree with them equally as well. Pasteur further states, in the *Bulletin Medicale*, Oct. 6, 1889, that trichinæ were found most frequently in American hams, which, he said,



are cured with a mixture of sea-salt and saltpetre. In regard to this statement, it may be said that the well-known infrequency of trichinosis in the United States, and the importance of the commercial interest in pork in France, would make it interesting to know a little more about the condition of Pasteur's experiments and investigations.

### Treatment of Acne of the Face.

The most rational treatment of facial acne should be based upon the following two principles: first, to allay the congestion of the skin as far as possible; second, to remove all causes which could give rise to the hyperemia of the face. To obtain these results, both internal and external remedies may be used. The direct care of the skin demands the principal attention. Every morning and evening the face should be washed with a fine sponge. The temperature of the water should be as high as the patient can possibly bear it. After washing, the skin should not be dried. Such a washing renders the skin extremely hyperemic. As soon as the water begins to evaporate from the face, the superficial blood-vessels become contracted, and gradually regain their lost tone. In many cases, this simple treatment will be all that is needed, and a speedy recovery will follow. In severer cases, however, the following solution may be employed:

R Hydrarg. bichlor. corros.,  
Ammon. muriat. . . . . aa gr. xv  
Emuls. amygdal. amar. . . . . f ʒ vij  
M. et fiat lotio.  
Sig. Apply morning and evening.

The following formula will be found to be of equal if not of greater efficacy:

R Aque destil. . . . . f ʒ ix.  
Sulphur. sublim. . . . . f ʒ i.  
Aetheris sulfuric . . . . . f ʒ iij-f ʒ jv.  
M. et fiat lotio. Sig. Apply morning and evening.

The practitioner may, however, come across cases of such a stubborn nature that even these lotions will fail to effect a permanent cure. In such cases, the only remaining course of treatment is scarification. This procedure never fails to quickly relieve the congestion of the skin, and also causes the acne pustules to rapidly disappear.

Regarding the best advisable diet to be pursued during the treatment of acne, little

need be said, other than that highly spiced and heating foods should be avoided.—*Allg. Med. Central-Zeitung*, Oct. 9, 1889.

### Bacillus of Tetanus.

At the recent German Surgical Congress in Berlin, Dr. Kitasato, of Tōkyō, Japan, demonstrated the tetanus-bacillus, and claimed that he had succeeded in obtaining this organism free from other bacteria, in experiments made in the Berlin Hygienic Institute. Tetanus serum was shown on agar-agar, and after twenty-four hours the bristle-shaped tetanus-bacilli were present, along with various other micro-organisms. If the culture was now exposed to a water-bath at 80° C. for half an hour, only the spores of the tetanus-bacilli retained their vitality; all the rest perished. Inoculations with the culture produced tetanus with the development of the typical bristle-shaped bacilli.—*London Medical Recorder*, Oct. 21, 1889.

### Chapped Hands.

The following is a pleasant and efficacious application for chapped hands:

R Quince seed . . . . . ½ ounce  
Water . . . . . q. s.  
Glycerin . . . . . 1 fluid ounce  
Alcohol . . . . . 4 fluid ounces

Macerate the quince seed with a pint of water for twenty-four hours, stirring frequently, strain with gentle pressure through muslin, and make up the volume to 1 pint with water; then add the glycerine and finally the alcohol containing the perfume, and stir briskly.—*Pharmaceutical Era*, Nov., 1889.

### Ulcer of the Stomach.

Dr. Tacke, in the *Deutsche Med. Wochenschrift*, Oct. 17, 1889, reports six cases of ulcer of the stomach, accompanied by hematemesis, which were cured by enforced rest of the organ. In this method all nourishment is given by enema until the ulcer has time to heal.

Of course the method suggested is only occasionally beneficial, yet it is surely worth a trial, as, in the majority of similar cases, all the efforts of the physician are fruitless.

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The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

## RARE SEQUELÆ OF TYPHOID FEVER.

Neuritis, osteitis and periostitis, are comparatively rare sequelæ of typhoid fever. They are so rare that many of the books do not mention their occurrence; and this fact may have induced observers to set down occasional cases as mere coincidences, and thus the sequelæ appear to be rarer than they really are. Very recently, however, Dr. R. Humphrey has met with a case of multiple neuritis following typhoid fever, of which he communicates an interesting account to the *British Medical Journal*. The patient was a little girl, three years old, whose typhoid fever was marked by cerebral symptoms. In the course of the fourth week the child complained of pain in the limbs, which were contracted; and the reflexes of the abdominal muscles were exaggerated. Then paresis of the legs, with abolition of the re-

action to electricity, occurred. At the end of eight days the condition of the right leg had improved, but paralysis had extended to the abdominal muscles on the left side. Subsequently the motor paralysis gradually disappeared, until after the eighth week, the affected muscles—except the anterior tibial and the abdominal—reacted anew to the Faradic current.

Too little study has as yet been given to this form of neuritis to enable one to speak with precision of its pathology. Dr. Ugo Bassi (*Osservatore*, No. 9, 1889), who has studied it in connection with a case observed by him in a mason, says that the alterations in the nerves are sometimes parenchymatous and sometimes interstitial; the lesions are, moreover, disseminated, healthy portions of the nerve alternating with those containing foci affected with neuritis.

Clinically the polyneuritis which follows typhoid fever manifests itself first by disturbances in sensation, and then by disturbances in motility. Its onset is sometimes abrupt and sometimes insidious; the soft parts over the seat of the neuritis are often cedematous, the skin being cyanotic and shining; and the local temperature is lowered. The average duration of the neuritis is from two to eight months, and, according to Bassi, the prognosis is in general unfavorable.

As regards the other rare sequelæ of typhoid fever—osteitis and periostitis—Sacchi has observed two cases, an account of which he gives in the *Rivista Veneta di Scienze Mediche*, I, 1889. Dr. Demuth has also seen one instance, a report of which is contained in the *Deutsche Medicinal-Zeitung*, No. 58, 1889. The patient of Dr. Demuth was a man, sixty-seven years old, who convalesced from typhoid fever after an illness of four weeks. Fifteen days later, however, he felt pain in the upper third of the humerus, a little below the surface. The skin over the seat of pain became red and swollen, and at the same time the fever recurred. Fluctuation gradually made its

appearance and a small quantity of mucopurulent fluid was evacuated by an incision. The bone exposed by the incision was red, and its periosteum was detached. A number of small sequestra were subsequently discharged. Appropriate treatment was followed by recovery in two months.

Ebermaier, in a communication to the *Deutsches Archiv für Klin. Medicin*, Vol. XLIV, 1889, recalls the fact that Freund bases his inaugural dissertation, published at Breslau, in 1885, upon twenty cases of osteitis following typhoid fever. Freund attributed the bone affection to the typhoid bacilli, but did not attempt to prove this conclusion by experiment. L. Fränkel and Simmonds subsequently experimented, but obtained negative results. Ebermaier, however, appears to have been more fortunate. He says he has succeeded in obtaining pure cultures of the typhoid bacillus on gelatine from the pus taken from the foci of osteo-periostitis with which two typhoid fever patients were affected. In conjunction with these two cases of osteo-periostitis, he gives an account of six other cases of the kind, which were observed in the medical clinic at Kiel.

The cases just referred to lead one to suspect that neuritis and bone affections following typhoid fever would be found more frequently if they were carefully sought for. There is very good opportunity to do this, especially in large city hospitals, where cases of typhoid fever may be met with at almost all times during the year. Careful study of the sequelæ of the disease would not only be interesting in itself, but might also lead to some valuable discoveries as to the etiology of the disease, and give information which could be usefully employed in an improved treatment. We commend this subject to our readers, many of whom have exceptional opportunities for study and clinical observation. In 1889, Dr. W. W. Keen, of this city, chose this subject for the Toner lectures, which he then delivered, and prepared a monograph which contains

material of the greatest interest and instructiveness, and one which ought not to be overlooked by any investigator who wishes to make his studies complete.

#### SURGICAL TREATMENT OF ANEURISM OF THE AORTA.

Attention is called in the *British Medical Journal*, Oct. 12, 1889, to a case of aneurism of the aorta treated by the insertion of wire according to the method originally introduced by Moore, of London, who in 1864 introduced twenty-six yards of fine wire into an aneurism of the ascending aorta and proposed this as a regular method. The case of Mr. Gould is not new, as it was reported by Dr. W. H. White and Mr. Pearce Gould, at a meeting of the Royal Medical and Chirurgical Society, April 12, 1887. The patient was a man 48 years old, who had noticed a swelling of the front of his right chest five months before he came under Dr. White's care. On his admission to the hospital, November 20, 1886, a prominent swelling was found in the position of the right mamma, extending from the second to the fifth rib, and from the edge of the sternum to the axilla. It was the seat of forcible expansile pulsation, and over it was heard a harsh systolic murmur. For two months an attempt was made to cure him by rest in bed, with restricted diet, and the administration of fifteen grains of iodide of potassium three times daily. About the middle of January the swelling increased rapidly in size and became very prominent. On January 11, Mr. Pearce Gould passed thirty-two feet of steel wire into the aneurism through a canula, introduced in the third intercostal space. Much blood was lost during the operation, but the hemorrhage was stopped with a compress. The tumor now became harder and the pulsation more heavy in character, and from one of the two punctures made at the operation considerable serum drained for several days. On the sixth day the pad of lint



was fastened on more firmly. The next day there was great swelling of the subcutaneous tissue over the aneurism. Two days later the skin became gangrenous, and the patient died. At the autopsy it was found that the first part of the arch of the aorta was greatly dilated, and a sacculated aneurism sprang from its upper part. The thoracic portion of the tumor had a distinct though thin sac, but that portion which protruded from the chest was destitute of a definable sac, and was limited by infiltrated muscle. The wire, mixed with loose fibrinous clot, proved a very dense mass nearly filling the sac, to which, however, it did not adhere. The fatal result appeared largely due to the absence of a distinct sac to the outer part of the aneurism, and to the effects of the formation of a hard, solid mass in the aneurism, combined with rather firm external pressure applied for the arrest of the serous oozing.

The usual method of treating aneurism of the aorta consists in absolute rest, restriction to the most limited diet, and the administration of iodide of potassium, digitalis or ergot, or some combination of these drugs. This method has given excellent results in a number of cases, and there are few in which surgical procedures are justifiable or likely to succeed.

One of the most successful cases of introduction of filiform material into an aneurism of the aorta was that of the late Professor Loreta, who, in 1884, introduced over two yards of silvered copper wire into an aneurism of the abdominal aorta, after opening the abdomen to gain access to it. The wound healed by first intention and the patient's condition improved rapidly and materially, the tumor diminishing from the size of a child's head to that of a walnut in seventy days, although the patient died three months after the operation from rupture of the aorta below the sac. Liebrecht, of Liège, in 1885, suggested combining the introduction of filiform material with partial occlusion of the lumen of the

aorta by means of a ligature. This might prove a useful procedure. The combination of galvanism with the introduction of wire—as practiced by Mr. Barwell, in 1886—might be expected, on theoretical grounds, to have some advantages; but they have not so far been demonstrated in practice.

On the whole, the management of these cases is still an open field for the enterprise and ingenuity of surgeons, and the patience and wisdom of medical men.

#### VOMITING OF PREGNANCY TREATED WITH MENTHOL.

The most unpleasant symptom accompanying pregnancy is undoubtedly the vomiting which often occurs, and this is especially serious because our present knowledge of its therapy is most unsatisfactory, and, in many instances, the physician is at loss to know how to proceed. It is not unfrequent that all therapeutic measures fail and relief is only obtainable by the induction of abortion.

Guided by the fact that the trouble must be regarded as a reflex neurosis, and that, theoretically, drugs which would depress the reflex excitability should also act beneficially in this complication, Dr. Sigmund Gottschalk, of Berlin, has used menthol in this disorder with marked success. He employed a solution containing fifteen grains of menthol in five and a half fluid drachms of alcohol and five fluid ounces of distilled water. Of this he gave a tablespoonful hourly. In a case so treated, and reported in the *Berliner Klin. Wochenschrift*, October 7, 1889, the vomiting ceased after the third dose, although previously other remedies had been used unsuccessfully. The patient was able to retain food and subsequently made a rapid recovery. The drug was continued for three days, the dose being gradually decreased.

The use of menthol is continually widening and there seems to be good reason on purely theoretical grounds for expecting that the results obtained by Dr. Sigmund were not

in the nature of a coincidence, but that they indicate a rational addition to the therapeutics of the vomiting of pregnancy.

#### DEPARTMENT OF HYGIENE AT THE UNIVERSITY OF PENNSYLVANIA.

A very important announcement was made November 11, in regard to the University of Pennsylvania, namely that Dr. John S. Billings has, with the approval of the Secretary of War and of the Surgeon General, accepted the position of Medical Director of the University Hospital, to which he was recently elected, and that the duties of this new position will be so arranged as not to interfere with his duties as Medical Officer of the army at the Surgeon General's office.

It is also announced that the University of Pennsylvania is soon to have a new laboratory of hygiene to cost about \$200,000; and that \$100,000 have been already collected for this purpose. The Department of Hygiene has been under the supervision of Dr. Samuel G. Dixon, since the death of Dr. N. A. Randolph, who was recently one of the Editors of the *MEDICAL AND SURGICAL REPORTER*.

It was rumored at first that Dr. Billings was to supersede Dr. Dixon; but the Provost of the University promptly denied this rumor and stated that Dr. Dixon was still Professor of Hygiene in the University and in charge of the Laboratory of Hygiene, which has been equipped through his exertions and liberality.

It does not yet appear just what Dr. Billings will do at the University, but the probability is that he will be at the head of the Department of Hygiene. For this he is abundantly fitted, as he is recognized as an authority upon the subjects of hygiene and hospital construction and administration. The elaboration of the plans for the construction of the Johns Hopkins Hospital, and his coming will be a valuable accession to the teaching force of the University of Pennsylvania.

#### CLINICAL LECTURES AND REPORTS OF CLINICS.

The readers of the *REPORTER* have no doubt noticed the development of the clinic departments in this journal, in the form of condensed reports of Clinical Lectures, and Reports of Clinics in a more colloquial style. This is a department which is believed to be of great value and interest, and no pains are spared to make it the best that is possible.

Special reporters are engaged to get material of this sort in the principal centres of the world, and more will be secured if the readers of this journal desire it. To secure to these reports a thoroughly trustworthy character, every one is submitted to the lecturer for correction or approval before it is published. They may all, therefore, be regarded as authorized by the lecturers. By this means it is hoped that the *MEDICAL AND SURGICAL REPORTER* will be a means of bringing back to many of its readers the familiar voices of their old teachers, or bringing to others the new and progressive doctrines of their old medical schools just as they would receive them if they were still "on the benches."

It is trusted that this plan will meet with the approval of our readers, and any suggestions in regard to it will be received with pleasure.

THE NATIVE EGYPTIAN AS A SUBJECT FOR SURGICAL OPERATION.—The native Egyptian is an extremely good subject for surgical operation. Clot Bey, the founder of modern medicine in Egypt, has it that "it requires as much surgery to kill one Egyptian as seven Europeans. In the native hospitals, the man whose thigh has been amputated at two o'clock is sitting up and lively at six." Shock is almost entirely unknown, and dread of an impending operation quite an exception. In explanation may be noted the resignation inculcated by their religion; the very small proportion of meat in, and the total absence of alcohol from, their diet; and in general their regular, abstemious, out-of-door life.

## BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the *REPORTER*.]

**HYGIENE AND PUBLIC HEALTH.** BY LOUIS C. PARKES, M. D., Assistant Professor of Hygiene and Public Health at University College, London, etc. 8vo, pp. xvi, 471. With illustrations. Philadelphia: P. Blakiston, Son & Co., 1889. Price, \$2.50.

Parkes' "Hygiene" has long held a deservedly high name as a text-book. It is to be regretted that both the book and the subject do not receive more careful study at the hands of medical students and practitioners. Good descriptions are given in it of water, its sources, purification, and examination for sanitary purposes; of the collection, removal, and disposal of excretal and other refuse; of air and ventilation; warming and lighting; climate and meteorology; soils and building sites; food, beverages, and condiments; exercise and clothing; and of the contagia, and communicable diseases and their prevention. The concluding chapters are devoted to some important statistics, and to an account of the standard solutions for quantitative analysis.

The book is well written, with conciseness but clearness. It is one of the best books on this subject for students, and is an excellent one to have on hand for ready reference by practitioners and officers of health.

**TRANSACTIONS OF THE NEW HAMPSHIRE MEDICAL SOCIETY**, at the Ninety-eighth Anniversary, held at Concord, June 17 and 18, 1889.

Dr. William Child, of New Hampton, declares, in his paper on "The Use and Abuse of Narcotics and Alcohols," that the narcotic and alcoholic habit cannot be transmitted as an inheritance. He believes that the time will soon be when a real inebriate will be put under restraint, and that prohibitory enactment alone will not cure or reform intemperance: "the power of a substantial, earnest, healthful, thoroughly Christianized mother is greater than that of all the organizations this side of heaven." Dr. G. P. Conn, of Concord, read a paper on the "Disposal of Garbage," in which he spoke of the great dangers arising from refuse, especially at summer resorts; but he had no definite plan to propose to remedy the evil. In the paper of Dr. W. B. Porter, of Walpole, on "Pneumonia; its Mortality and Therapeutics," the treatment of pneumonia by wet compresses, cold or hot, with suitable adjuvants, is commended. He also expressed himself as favorably impressed with the results obtained by Dr. Turner, in the treatment of pneumonia with inhalations of cold air. The discussions on the three papers mentioned was earnest and instructive.

The appearance of the volume speaks well for the New Hampshire Society, and indicates a healthy condition of the profession in that State.

**ON THE RESPIRATORY FUNCTIONS OF THE NOSE AND THEIR RELATION TO CERTAIN PATHOLOGICAL CONDITIONS.** BY GREVILLE MACDONALD, M. D. (Lond.), Physician to the Throat Hospital, Golden Square, W. 8vo, pp. 72. Boston and New York: Houghton, Mifflin & Company, 1889. Price, \$1.25.

Dr. Macdonald records in this brochure the results of his investigations to determine three things: the degree to which the temperature of the inspired air is raised by the nose; the degree of humidity acquired under the same circumstances; and, thirdly, the chem-

ical changes that take place in the air by passing through the nose alone. By a clever device of tubing containing a thermometer, the air was inspired by suction with the lips, in such a way that it had first to pass in at one nostril and out at the other before reaching the mouth; thus the temperature of the air was registered after it had passed through both nasal fossae and out of the second nostril. Four to six deep inspirations generally sufficed to raise the thermometer to the highest point, when the inspired air was of an ordinary temperature. The temperatures recorded in the experiments indicates the remarkable fact that, whatever the atmospheric temperature, the inspired current of air on passing through the nose alone is raised or lowered in temperature, approximately to that of the blood.

To determine the second question—the degree of humidity acquired by the air passing through the nose—a known volume of dry air was made to pass through the nose and then through tubes containing calcium chloride, previously weighed. The author found that air in passing through the nose alone is completely saturated with moisture.

With regard to gaseous exchanges, the author concludes from his experiments that they take place in the nose between the gases of the blood and those of the air, just as they do in the lungs, and that to a not inconsiderable extent. The quantity of carbonic acid exhaled by the nasal mucous membrane is said to be proportionate to the number of degrees of temperature to which the air is raised.

The author's experiments are clever and interesting; they seem to establish the fact that the nose warms and moistens the air, and that it takes part in gaseous exchanges. The book is well written, the apparatus used in the experiments clearly illustrated, and the publishers, on their part, have maintained their deserved reputation by presenting the book in most handsome style.

**A TEXT-BOOK OF ANIMAL PHYSIOLOGY**, with introductory chapters on general biology and a full treatment of reproduction. For students of human and comparative (veterinary) medicine and general biology. BY WESLEY MILLS, M. A., M. D., L. R. C. P. (Eng.), Professor of Physiology in McGill University and the Veterinary College, Montreal. 8vo, pp. xxii, 700. With over five hundred illustrations. New York: D. Appleton & Company, 1889. Price, \$5.00.

Dr. Mills has endeavored in the present work to apply to physiology the teachings of Embryology and of evolution. This, he thinks, has not been done hitherto. He strongly protests against the common tendency to speak of certain conclusions, for various organs and functions, as though they applied to these organs in whatever group of animals found, or, at all events, in the case of man, no matter what the species of the animal that had been experimented on. The subjects of development and reproduction are introduced early in the book, for the purpose of using certain embryological facts to throw light upon the different functions of the body, and especially their relations and interdependence. We are disposed to think that both the change from the usual custom and the reasons for it are good. Clinical and pathological facts are introduced from time to time in order to indicate to the student how physiology bears upon medicine. This is also a commendable feature of the book.

The author says, in his preface, that his aim has been to make the book, from first to last, educative. He has succeeded; it is full of sound physiological



knowledge, presented as clearly as the inherent difficulties of the subject permit. While the book is large, it does not impress one as ponderous or bulky. Several things contribute to this desirable end: the paragraphs are numerous, and so are centre-heads and side-heads; so that the contents of the chapters are rendered easier to study and easier to remember. Moreover, the illustrations are copious and admirably clear; and, more than all, each chapter concludes with a summary—a method of generalizing which is extremely helpful to students.

We commend the book most heartily to students of physiology, human or comparative, as perhaps the best exposition of physiological knowledge from a modern point of view which has yet appeared in English.

### LITERARY NOTES.

The Christmas number of *Scribner's Magazine* is an unusually handsome one, and this is saying a great deal; for *Scribner's Magazine* is already one of the very best in printing, in paper, in literary contents, and in illustrations. An interesting paper is that by Dr. William Perry Northrup, on "The Pardon of Ste. Anne d'Auray," which is abundantly and beautifully illustrated. Another extremely attractive one is that by Mr. Edgar Mayhew Bacon, called "Notes of a Subtropic Study," which is calculated to attract many a traveler to the delights of the Bahamas. Altogether the December number of this magazine furnishes abundant evidence how *Scribner's Magazine* has so quickly attained a circulation of over 125,000 copies.

### NOTES AND COMMENTS.

#### New Remedies in the Treatment of Phthisis.

We have had occasion from time to time to refer to various new methods and remedies in the treatment of phthisis, and have quoted at some length the results obtained by Houzè with tannic acid, by Ransome with inhalations of oxygen, and the excellent *résumé* of Shingleton Smith of the drugs suggested by the germ theory of this disease.

Paul Chéron (*L'Union Médicale*, Nr. 104 and 105, 1889), in a review of the therapeutics of phthisis adopts the classification of Gilbert, and divides the new remedies directed towards the relief of this disease into: (1) Inhalations; (2) powders; (3) gaseous applications (method of Bergeron); (4) injections; (5) internal antiseptic medications; (6) modifications in climate; (7) non-medical external methods; and (8) symptomatic medication. Carbonic acid, since the experiment of Weill, has not received much attention; Nothnagel and Rosback doubt its utility. Sulphydic acid has been employed by Allevard and studied

by Niepce; the patients respired during an hour 52 litres containing one-half of the gas, and good results were obtained in the first and second stages of the disease. Sulphurous acid, as we know from the researches of Dujardin-Beaumetz, produces modification of the catarrhal state with diminution of the expectoration and lessening of the cough. Inhalations of iodoform and of terebinthinate essence have yielded contradictory results; benzoate of soda has been abandoned.

Hydrofluoric acid has been, as is well known, the subject of much experimentation, and the following are some of the results: Raimondi reported to the Congress on Tuberculosis, in Paris, 128 cases treated by the inhalation of the vapors of this acid with a cure (disappearance of the bacilli) in 28, amelioration in 18 who had cavities; 5 died of acute pulmonary processes. Gaeger (*Deutsch. med. Wochenschr.* 29, 1888) obtained in 5 cases disappearance of the bacilli from the sputum and considerable diminution in the physical signs; in 7 cases there was notable local improvement; in 2, with laryngeal phthisis, the inhalations provoked inflammatory reaction. Andollent concludes from seven observations that the inhalations act rather upon the general tubercular condition than upon the local pulmonary lesion. He secured a rapid return of appetite and lessening of the dyspnoea by the use of this method. Tisné (*France med.* 82 and 83, 1889) tried inhalations of hydrofluoric acid vapor in 46 cases, 32 of which had not passed the second stage of phthisis, and produced amelioration in 13 instances; in 16 the disease remained stationary, while in 3 it was aggravated. In emphysema and asthma Tisné was able to confirm the reservation of Chevy that the inhalations must be employed with great caution, as they may provoke attacks of suffocation. Gilbert, who has treated 30 cases, with benefit to 19, negative results in 3, aggravation of the disorder in 3, and 5 deaths, recommends the following formula, which is sufficient to use for six days:—

R Hydrofluoric acid,  
Water . . . . . aa 3x

and concludes from his study that this method gives the best results among the newer inhalation-remedies. This conclusion is by no means in accord with the observations of all observers, thus Lépine, it will be remembered, was unable to dis-

cover any improvement in his cases, and Doremberg failed to secure beneficial results in the treatment of phthisis. Neither is this statement in accord with direct experimentation, since we know that Graucher and Chautard in their researches reached the conclusion that the vapor was of little value, and that, although if used for prolonged periods of time, it diminished the virulence of the tubercle bacilli, it did not kill them.

Among the internal remedies Chéron reviews the results obtained by Laskoff (*Nouveaux Remèdes*, 1889, 350) with the use of homeriana, a Russian plant which has an irritating oil for its active principle, and which the author prescribes in the form of a decoction or infusion:

R Infusum homerianæ . . . . . ʒj  
Distilled water . . . . . Oij  
To be taken in 24 hours.

With the exhibition of this remedy he obtained beneficial results in 90 out of 112 cases of phthisis, securing reduction of the temperature and diminution in the amount of the sputum.

Lashkewick has used the borate of ammonium in the dose of  $3\frac{1}{2}$  grains thrice daily, and found under its influence a notable lessening in the quantity of expectoration, and reduction in the febrile reaction.—*Univ. Med. Magazine*, November, 1889.

#### Death after Ether Anæsthesia.

A case of death from ether inhalation recently occurred at Bellevue Hospital. The patient was a male, and the ether was being given by Dr. Theodore, of the house staff of the hospital, preliminary to an operation upon the throat. The coroner's jury in the case rendered a verdict that death was caused by asphyxiation due to the administration of ether, complicated with cystic degeneration of the kidneys. Dr. Dunham, however, is of opinion that death was due to heart failure, rather than asphyxiation. All the usual precautions were taken in the use of the anæsthetic.—*Boston Med. and Surg. Journal*, Nov. 14, 1889.

#### Removal of Powder Stains.

Powder stains are frequently a source of annoyance from a cosmetic point of view. The methods hitherto in vogue for their re-

moval have been more or less imperfect. The latest is, however, quite successful in its action and is very easily applied. The following solution is painted on the stains:

R Ammonii biniodidi  
Aque destillatæ . . . . . aa fʒi.

This will turn the stains to a reddish color. To get rid of the red discoloration, it is only necessary to paint the affected parts with dilute hydrochloric acid.—*Medical Chips*, Sept., 1889.

#### New Tænicides.

Areca nuts are brought from India, Ceylon, and the Philippine Islands. The *Areca Catechu*, of which they are the fruit, is a palm. Arecaline is the active principle, and it is to this that the tænicide property of areca nuts is due. In its chemical composition and its properties, this alkaloid bears a marked resemblance to pelletierine, the active principle of pomegranate. Arecaline is an oily, volatile liquid, with an alkaline reaction; it is soluble in alcohol, ether, chloroform, and water. With acids it forms soluble salts.

Areca nuts are given in the form of powder; the dose is from a drachm to a drachm and a half. The alkaloid has not yet been administered with tænicide intent.

The rules for the administration of the areca powder are much the same as those given for the administration of pomegranate bark or pelletierine. Arecaline being a poison to the worm, benumbing and paralyzing it for the time, the administration of the nuts must be followed by an active purge to remove the entire worm before it has time to recover from its stupor. It is well to precede the ingestion of the remedy by a milk diet, and by a purgative or enema the evening before, that the intestines may be cleared of fecal matters, and that the drug may have a better chance of coming in contact with the worm. The helminth is generally expelled entire four or five hours after the ingestion of the remedy.

Another tænicide is the fruit of the well-known cocoanut, *cocos nucifera*. For a long time the albumin of the cocoanut has been prescribed as a tænifuge in countries where the *cocos nucifera* grows. Berenger-Teraud, however, says that he has made trial of this remedy a great many times, and only once out of twenty-four succeeded in ob-

taining the expulsion of the head of the worm.

Pariso, of Athens, writes that while he resided in Abyssinia, where it is the fashion to have tape-worms, he chanced to discover the tænicide properties of this albumin. On his return to Athens, he tested it thoroughly, and always with satisfactory results, the whole worm being expelled dead.—*Boston Med. and Surg. Journal*, Oct. 10, 1889.

### Stuttering.

It is a well-known fact that stutterers, when speaking in a whispering voice, show no impediment of speech. A new method of treatment has been advocated by Dr. Coen and is as follows: In the first ten days speaking is prohibited. This will allow rest to the voice, and constitutes the preliminary state of treatment. During the next ten days speaking is permissible in the whispering voice, and in the course of the next fifteen days the ordinary conversational tone may be gradually employed.—*Kansas Med. Jour.*, Oct., 1889.

### Roach Destroyers.

Roaches may be exterminated if the following powder is liberally sprinkled in the cracks and corners of their rendezvous.

Borax	.....	37 parts
Starch	.....	9 "
Cocoa	.....	4 "
Mix.		

### Administration of Anæsthetics.

At a meeting of the Brooklyn Surgical Society, June 6, 1889, Dr. Pilcher said: The experience of the past ten years has led me to give preference to that very popular and common inhaler known as the Allis inhaler.

Practically, for the administration of ether, it has seemed to me that the simple cone of Allis, used with that intelligence and care which ought to accompany the administration of an anæsthetic always, gives us all we desire, with the one exception of not being economical of the anæsthetic. It is true, I have seen the anæsthetic poured through it on to a patient, which ought not to be, and need not be. Of course a recent graduate, though a fool, will not err in this way in the use of ether with this instrument

presented by Prof. Wight; he couldn't pour the ether into the mouth of the patient if he should try. Certainly this is an advantage if to such hands the giving of an anæsthetic must be entrusted. I certainly like this instrument. It seems as simple as anything of the kind can possibly be and answer to the indications.

I am convinced that in a very considerable portion of cases the use of ether as an anæsthetic is dangerous, and have been rejoiced to see the tendency, which is so marked in the profession at present, to study the advantages and dangers of different anæsthetics with regard to different patients, and to suit to particular patients the anæsthetics which experience shows to be the best adapted for them; so that there is rapidly becoming less partisanship with regard to this or that anæsthetic. It is a marked feature, for which I think all thoughtful surgeons should rejoice, in the conditions of to-day. The long administration of ether is certainly depressing. Even the short administration of ether has a more or less irritating effect upon the respiratory passages. Ether to any considerable extent has also an irritating effect upon the urine-secreting apparatus, and it is certainly wise for us to take these things into account in choosing our anæsthetic; and if for any reason we feel we must use ether as an anæsthetic, it seems especially wise that we should take advantage of some such device as this which has been presented to us this evening, which would diminish as much as possible the irritating effect of that particular anæsthetic.

In many cases I am convinced that chloroform should be used as the anæsthetic rather than ether; in all cases where there is recognizable irritation of the bronchial and pulmonary tissues, also where there is a diseased condition of the urinary secretive apparatus; that in young children, likewise, who as a class have been shown by experience to be peculiarly pleasantly affected by chloroform, it should be used; and at the other extreme of life, in the aged, who as a class either already suffer from or are on the verge of renal and pulmonary degenerative changes.

Now, as to the methods of administering chloroform: The most convenient and safe inhaler is always at command in a common tumbler or a common teacup, into the bottom of which a handkerchief can be put so that it shall be an inch or two away from the nostrils or mouth, and which, when put over the mouth and nose, cannot be forced



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so close down upon the cheek upon either side that there will not always remain still considerable apertures at those points for the abundant admission of air with the chloroform vapor. This is nothing new, but I have had occasion so many times to suggest it to men of large experience and of age in the profession, whom I have seen attempting to administer chloroform in both wasteful and dangerous methods, that possibly it may not be out of place to notice this method in this connection.—*Brooklyn Med. Journal*, November, 1889.

### Sycosis.

For the treatment of sycosis, or barber's itch, Dr. Rosenthal recommends that the seat of the affection be closely shaved every day and that the following ointment be rubbed in twice a day:

R Acidi tannici, . . . . . gr. xlv  
Sulphuric precipit., . . . . . 3 jss.  
Zinci oxidi,  
Amyli, . . . . . aa 3 iv  
Vasellini, . . . . . 3 j  
M. Sig.—Use twice daily.

In a month, he says, nothing remains of the eruption but a very slow disappearing erythema.

### Cocaine in Vomiting.

Dr. M. W. Everson, in the *College and Clinical Record*, September, 1889, speaks of the value of cocaine in the vomiting of pregnancy and the obstinate vomiting of gastric ulcer and cancer. He has also found it of use in the vomiting of entero-colitis of children, a disease which is so frequent in our large cities during the heated term, and in which vomiting is often so prominent a symptom. In the latter affection it is best given in combination with bismuth. To a child two years of age he gives  $\frac{1}{8}$  grain of the hydrochlorate at a dose, and repeats it every few hours *pro re nata*.

In the vomiting of pregnancy  $\frac{1}{8}$  to  $\frac{1}{4}$  grain three times daily will generally be sufficient. A formula which has proved useful in the latter affection is the following:—

R Cocain. hydrochlorat., . . . . . gr.  $\frac{1}{8}$   
Ext. nucis vomice, . . . . . gr.  $\frac{1}{6}$   
Pulv. asafetide, . . . . . gr. ij.—M.  
Fm. capsu' s j.

Sig.—Three times a day, a half hour before eating.

Cocaine will be found of value where other remedies fail. Dr. Everson has found it successful in those cases of vomiting of pregnancy in which the so-called specifics, oxalate of cerium, etc., have failed. In gastric cancer it will often arrest the vomiting for days at a time, thus giving the stomach rest.

The formula he has used in a number of cases of cancer is the following:—

R Cocain. hydrochlorat., . . gr.  $\frac{1}{8}$ — $\frac{1}{4}$   
Thymol, . . . . . gr.  $\frac{1}{4}$ — $\frac{1}{2}$ —M.  
Ft. pil. j.  
Sig.—Three times daily.

In every case in which it was used the vomiting and pain were noticeably lessened, and the patient was made vastly more comfortable.

But regardless of the above special diseases cocaine is of use in vomiting from any cause. The most desirable way to administer cocaine is in pill form, but it may be given in solution when a proper vehicle is added. The drug can be given in suitable doses without fear of depression.

### Epilepsy Following Vaccination.

Dr. Althaus has reported a case, in the *London Med. Recorder*, Oct. 21, 1889, in which epilepsy was apparently set up by vaccination. A healthy lad of 19, who, neither in his family nor in his personal history, showed the slightest trace of any neurotic tendency, was revaccinated in the ordinary way. The vaccine caused somewhat severe symptoms, but these soon passed off. A month after the operation he was seized with an epileptic fit, and since then he has had attacks of great severity about once a month. There is no doubt as to the nature of the fits, and no other cause but the vaccination can be assigned for them.

### Laxative Powder.

The following will be found an agreeable laxative:

R Powdered anethum  
Powdered senna } each 3 drachms.  
Sublimed sulphur }  
Powdered cream of tartar . 1 drachm  
Powdered liquorice . . . 4 drachms.  
Powdered sugar . . . . . 1½ ounces.

M.—Sig. Teaspoonful to dessertspoonful to be taken at night in a little water.

—*Pharmaceutical Era*, Nov., 1889.

## NEWS.

—An effort is being made to start another Woman's Medical College in Cincinnati.

—Dr. Richard Volkmann, the famous surgeon of Halle, died November 28, 1889.

—The Idaho Insane Asylum was destroyed by fire on November 25, and eight lives were lost.

—Subscriptions amounting to \$31,000 have been raised in Paterson, New Jersey, for the erection of suitable buildings for the General Hospital of that city.

—Dr. R. S. Huidekoper has resigned the Professorship of Internal Pathology and Zootechnics in the Veterinary Department of the University of Pennsylvania.

—By a gift of \$5,000 to the Presbyterian Hospital in Philadelphia, Mrs. E. P. Baugh and son have endowed a free bed in that institution in memory of the late Mr. Baugh.

—A chair of Hygiene and Physical Culture has been endowed, in the sum of \$25,000, at the Pennsylvania College at Gettysburg, by the parents of the late Dr. Charles H. Graff.

—A Training School for nurse girls is to be opened this month at the Babies' Hospital in New York city. This hospital is now permanently located on the corner of Fifty-fifth Street and Lexington Ave., and has a capacity of 35 beds.

—An epidemic of influenza is spreading in St. Petersburg, Russia. Half of the population of the city is said to be suffering from the disease. Among the victims are the Czar and Czarina and two of their children. There have been no fatal cases.

—Cholera is still on the increase in Persia, and the Russian authorities propose establishing at Bakou and Julfa a general quarantine against arrivals from Persia. The disease has now reached Kermansha, but has not yet made its appearance at Teheran.

—Dr. John S. Billings, with the approval of the Secretary of War and of the Surgeon General, has accepted the position of Medical Director of the University Hospital in Philadelphia. He will not relinquish his position as Medical Officer of the Army at the Surgeon General's Office.

—A new use for carrier pigeons has been found in Russia. The birds are used to carry negatives of photographs taken from balloons. The negatives are placed in envelopes impenetrable to light and can be conveyed in safety to great distances. These envelopes are tied to the birds' feet.

—The officers and friends of the Univer-

sity of Pennsylvania have organized a stock company under the name of the University Press for the purpose of controlling under one efficient direction the present periodical publications of the University, and of establishing such new magazines as the needs of the institution may suggest.

—By the late Dr. Ricord's will the Academie de Médecine was left 10,000 francs, the French Surgical Society, 5,000 francs, and the Society for the Advancement of Medicine in France, also 10,000 francs. His large library was bequeathed to the Midi Hospital. It is also stated that the Midi Hospital shall hereafter be called the Ricord Hospital.

—Acting upon suggestions in a communication signed by Drs. S. Weir Mitchell, D. Hayes Agnew, William Pepper, J. W. Da Costa, W. W. Keen, H. C. Wood, and William Hunt, the Board of Health of Philadelphia, on November 29, adopted a resolution in which it "strongly advises the boiling of all drinking water and milk at least 20 minutes, as the simplest and best means of purification."

—The forty-third anniversary of the New York Academy of Medicine was celebrated on the evening of November 21, 1889. Dr. William M. Polk delivered an address on "The Relation of Medicine to Some of the Questions of the Day." The President, Dr. Alfred L. Loomis, stated that the building fund of the Academy now amounted to \$150,000 and it was hoped to realize \$70,000 from the sale of the premises now occupied. Subscriptions of \$20,000 additional were still needed for the completion of the new building.

—Dr. Lauder Brunton, who, as our readers are aware, proceeded to Hyderabad on Oct. 4, on behalf of *The Lancet*, for the purpose of repeating and amplifying the experiments made by the Hyderabad Chloroform Commission in 1888, with a view to confirm or correct its conclusions, telegraphs to that journal that the work is progressing in an entirely satisfactory manner. He has completed 275 experiments on dogs and monkeys, and the result so far has been to practically confirm the conclusions arrived at last year by the Hyderabad Commission. The telegram adds that the Nizam's Government is acting in a most liberal manner, and, in conclusion, states that the Nizam and the British Resident paid a visit to the laboratory on Monday last and inspected the work.